

Child & Adolescent Development Resource Book

Sponsored by the

Child Welfare Academy

A partnership of the
University of Maryland School of Social Work and the
Maryland Department of Human Resources



Adapted with permission from:

“Child and Adolescent Resource Book”, The Center for Child and Family Studies, College of Social Work, University of South Carolina

“Child Development Milestones”, The Northern California Children and Family Services Training Academy, University of California at Davis

Brittain, C., & Hunt, D. E. (Eds.) (2003). *American Humane’s Helping in child protective services: A competency-based casework handbook*. New York: Oxford University Press

Table of Contents

How to Use This Resource Book.....	4
Principles & Theory.....	6
Principles of Development	7
Special Topics in Development.....	9
Foundations	14
Tables & Charts	20
Fetal Development.....	21
How to Use the Growth Charts.....	23
Growth Charts—Girls (0 through 2).....	24
Growth Charts—Boys (0 through 2)	26
Growth Charts—Girls (2 through 19).....	28
Growth Charts—Boys (2 through 19)	29
Tables of Developmental Characteristics and Markers	30
Observation Notes	32
Infancy (0 to 12 Months).....	33
Toddlerhood (12 to 36 Months).....	37
Early Childhood (3 to 6 Years).....	41
Middle Childhood (6 to 11 Years).....	46
Early Adolescence (11 to 15)	51
Adolescence (15 to 19).....	54
Normal Developmental Challenges and Strategies	57
Challenges Beyond Normal Development.....	66
Prenatal Risks	67
Failure to Thrive	68
Children with Disabilities	70
Alcohol and Drug Exposure	72
Effects of Maltreatment on Development.....	73
Effects of Separation and Loss on Children	77
Factors that Influence a Child’s Reaction to Parent Separation or Loss.....	79
Phases of Grief.....	81
Glossary	86
Suggested Resources.....	89

How to Use This Resource Book

This Child and Adolescent Development Resource Book was created for use as both a training tool and a reference for child welfare workers. Information in the book is presented in training lectures and activities. Using the book in training should facilitate its use in practice. Workers are encouraged to keep the book handy after training for quick reference in working with child and adolescent clients and their families.

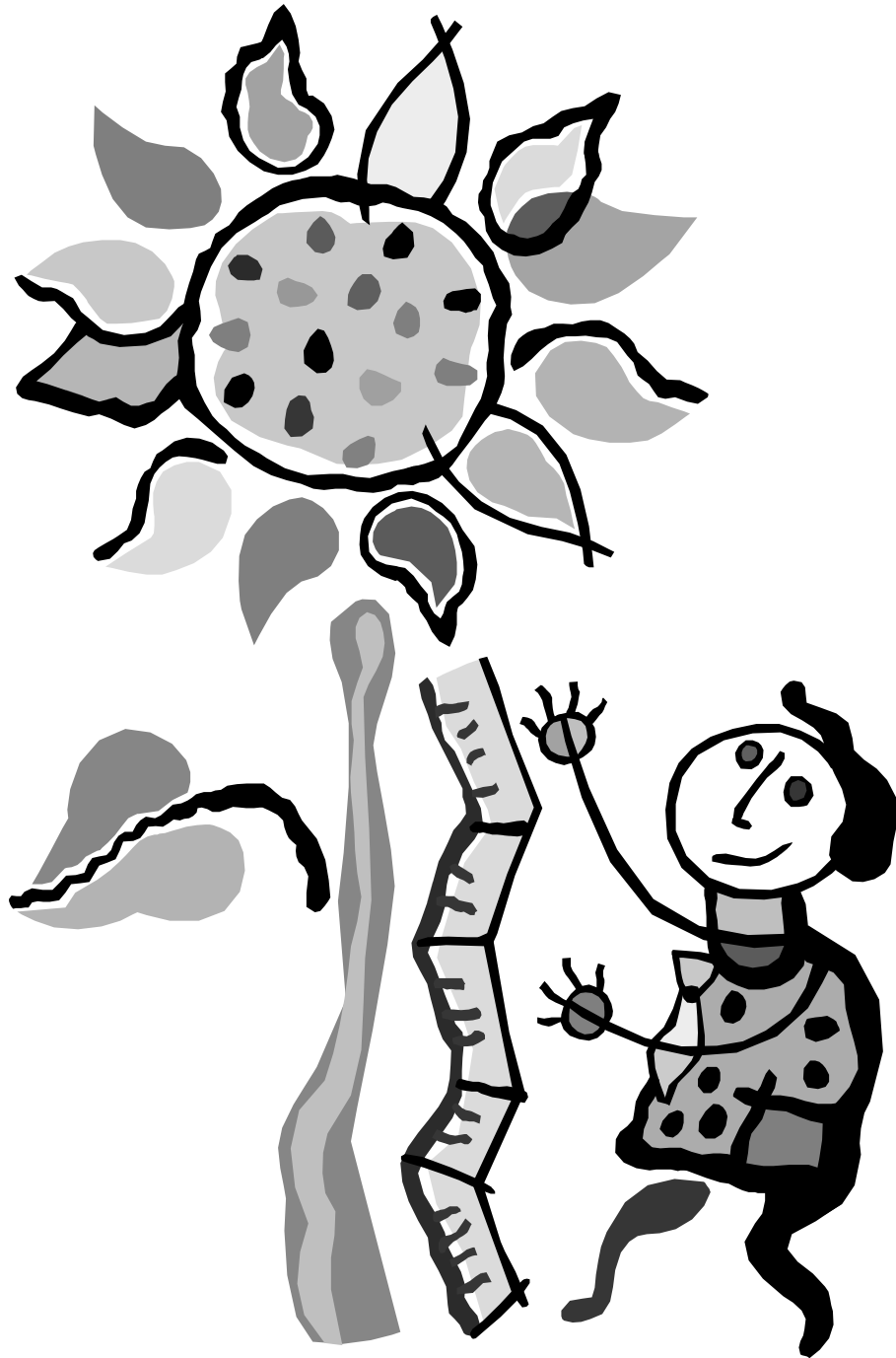
The first section of the book contains information on principles of development, and then goes into more depth on key topics, such as attachment and brain development. It also briefly discusses major theorists to help the worker understand the foundations of our current knowledge of human development. Workers will find that at least a nodding acquaintance with it will help them understand something about how our knowledge has evolved, and continues to do so.

The second section contains charts and tables that provide general guidelines on what to expect of children and adolescents at different ages and stages of development, as well as “red flags” for developmental concerns and tips for enhancing development. These are divided into six stages of development, from birth through adolescence, plus information on fetal development. In the training, we treat development in three domains: physical, cognitive/linguistic, and socioemotional. We are treating language development as part of cognitive development, but in the tables, because of the amount of information on language development and its importance, we have given it a separate heading. Moral development, while part of the socioemotional domain, also has been given a separate heading for the same reason. This section also covers information on common issues in normal development that can cause stress for parents (e.g., potty training) and offers tips for enhancing development and dealing with problems caused by normal developmental tasks at various ages.

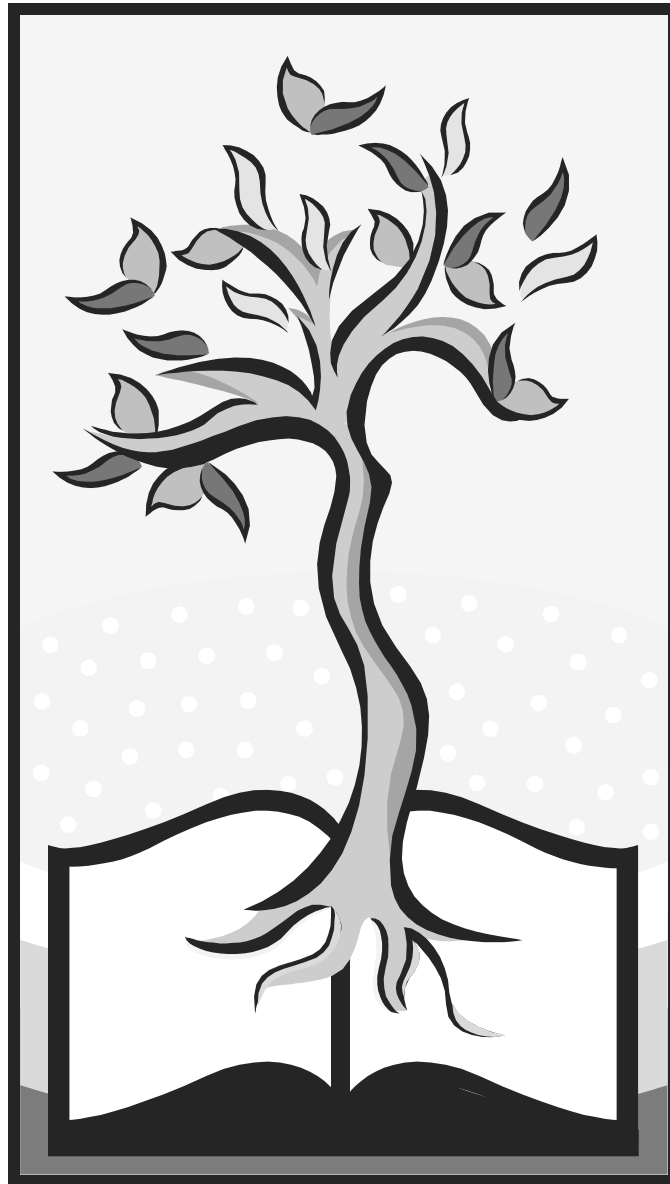
The child welfare worker who can recognize normal milestones can also spot deviance from the norm, try to ascertain its causes, and suggest the most appropriate interventions. It is important to remember, however, that variations somewhat before and after the “normal” time for an individual to complete a developmental task are also considered within the norm. Though the sequence of development is consistent for all individuals, each individual develops in a unique way.

The third section includes information to help workers understand developmental issues that go beyond normal development, including developmental disabilities, the effects on the child of fetal alcohol and drug exposure, and common effects of maltreatment on growth and development.

The Glossary defines universal terms and language that will help the worker understand information on child and adolescent development, talk with families and other professionals about it, write reports, and request appropriate services. The “Suggested Resources” section contains books, articles, book chapters, and websites that may be useful to the worker who wants further knowledge and understanding. Some of these sources were used in the development of the training for which this book was compiled.



Principles & Theory



Principles of Development

Growth and development are the result of both nature and nurture. They are influenced by a combination of genetic, biological, environmental, and experiential factors. An individual child's progression through the developmental stages is the result of a unique mix of physical and mental predispositions and attributes, as well as environmental conditions, such as poverty, prenatal drug exposure, or empathic parenting.

Development occurs across a number of interconnected domains. Development in each domain is closely interwoven with development in the others, though it may not proceed evenly across domains in a parallel fashion (e.g., language development may at times outstrip physical development or vice versa.) In this book, we consider three major domains: physical, cognitive/linguistic, and socioemotional. Different writers may divide domains somewhat differently—for instance, treating moral development or language development as separate domains rather than a part of socioemotional or cognitive development. But, however it is presented, the information is essentially the same.

Development is progressive over time. It unfolds in a series of stages in a consistent sequence. Though each individual develops in a unique way, the sequence of development is consistent for all individuals. For example, in general, children gain control over their bodies from head to toe and from the center out (Fahlberg, 1991.) An infant will be able to focus his or her eyes and follow an object before being able to lift his or her head.

For each stage of development, there are milestones that tell whether or not the individual has achieved typical, or “normal,” development in the three domains. More broadly, there are developmental tasks that each individual needs to complete for each major developmental stage in each domain before he or she can proceed with optimum hope for success to the next stage. If tasks at a particular stage are not adequately completed, problems are likely to appear at future stages of development.

Individuals' development does not always proceed evenly or at the same rate. Some degree of variation around what is considered the normal time for an individual to complete a developmental task should still be considered within the normal range. These normal variations would be smaller in the case of an infant in a period of rapid growth and development, but might be as much as six months for an adolescent.

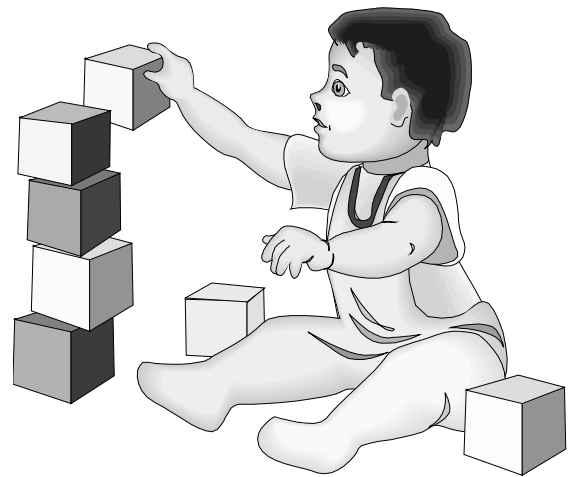
Development proceeds most rapidly in the earliest months and years of life, especially before age five. Deficiencies in care at that stage can have especially serious effects on physical, cognitive, and social development. For example, rapid brain and body growth before age two makes infants highly susceptible to malnutrition, which, if not corrected, can lead to brain damage, mental retardation, and/or growth retardation.

For most individuals, growth and development occur within a family or family-like context. Thus, the parent figures are the ones who are primarily responsible for seeing that the child has needed supports for development and is protected from conditions that would impede development. To do this, caregivers need to understand the developmental process.

Abuse, neglect, and poor parenting can severely undermine development, not just in the psychosocial domain, but also in the moral, physical (e.g., failure to thrive,) linguistic, and cognitive domains.

The effects of maltreatment on development are the result of a complex interaction of factors, including nature, duration, and severity of maltreatment; developmental stage of the child; need; physical and psychological constitution of the child; and environmental and interpersonal conditions that act to increase or mitigate risk. The prenatal and infant periods are periods of highest risk developmentally.

For individuals who are victims of maltreatment, or who have conditions that may handicap normal development, it is important to understand optimum developmental possibilities within each domain at each stage and what can support or impede optimum development.



Special Topics in Development

This section includes an overview of development in several areas that have lifelong implications for a child's functioning. Areas included are attachment, language development, brain development, and emotional intelligence. In-depth information on these and other areas is provided by age level in the next section, Tables and Charts.

ATTACHMENT

Attachment refers to the close emotional bond children normally form with those who care for them early on—a mother and/or father, and/or other caregivers. This happens through regular, positive contact and interaction between the infant and the caregiver(s) or other familiar figures, as when the adult feeds, comforts, plays with, and talks with the infant and the infant responds. In this way, ideally, the infant learns that he/she can communicate a need to the caregiver (e.g., by crying) and get a response that meets the need.

You can see attachment forming in the way a baby responds to the figure to whom he or she is becoming attached; for instance, the baby touches the parent's face.

Parental behaviors that promote secure attachment are sensitive and loving handling of the infant and responses to his or her emotional states; for example, not over handling or over stimulating a tired baby.

The infant also plays a part, ideally, by responding to and interacting positively with the caregiver. It is harder for some parents to respond in a consistently loving way to an infant who is often irritable and/or unresponsive.

John Bowlby, a child psychiatrist, first drew attention to the clinical importance of the concept of attachment (Bowlby, 1969.) He theorized that children have an instinct to seek or maintain proximity to their caregiver, which he called the attachment instinct. He postulated that the pattern of an infant's early attachment to parents would form the basis for all later social relationships. According to Bowlby, children typically exhibit what he called secure-base behavior, leaving the caregiver to explore their environment and returning to seek comfort when they are anxious. He hypothesized that when the caregiver was unavailable or only partially available during the first months of the child's life, the attachment process would be interrupted, leaving enduring emotional scars and predisposing a child to behavioral problems. A child with separation anxiety also would be likely to spend less time exploring his or her environment, which could interfere with future development in the physical or cognitive domains.

Bowlby's colleague, Mary Ainsworth (Ainsworth, Blehar, Waters, & Wall, 1978,) went on to describe four patterns of attachment that may develop based on early interactions between child and caregiver. These are:

- **Secure attachment** – Infants separate readily from their caregivers when caregivers leave, but then happily greet them when they return. Infants use their caregivers as a secure base, leaving them to explore, but then returning to them for occasional reassurance.
- **Avoidant attachment** – Infants rarely cry when their caregivers leave, and avoid them upon their return. They do not reach for their caregivers in time of need.

- **Ambivalent or resistant attachment** – Infants become anxious even before their caregivers leave, but then show ambivalence toward them when they return (seeking them out and then resisting contact with them.) These infants do little exploring and are hard to comfort.
- **Disorganized-disoriented attachment** – Perhaps the least secure attachment. Infants show inconsistent, contradictory behavior. They greet their caregivers, but then turn away or approach them without looking at them. They seem confused and afraid.

The child who is **securely attached** generally prefers the parent to a stranger and is comfortable leaving the parent to explore farther afield, but will then return to the parent. Children who are not so securely attached may not appear to prefer the parent, or may indiscriminately seek attention and affection.

Attachment is important because it is the first kind of relational experience the baby has and thus becomes the foundation for other relational experiences in life.

Many theorists believe attachment is necessary for the attainment of developmental tasks. For example, Erikson describes the primary task for the first period of life as establishing “basic trust versus basic mistrust.” The child who learns through attachment that his or her needs will be met is more able to resolve this task positively, and is ready to proceed along the normal developmental path. The child who does not learn this early in life may be at a disadvantage developmentally, because this child cannot trust that his/her needs will be met.

Securely attached infants are more likely to become securely attached children. These children are more likely to show:

- Self-esteem;
- Independence and willingness to explore on their own;
- Social and academic competence;
- Trust in people;
- Willingness to ask for help when they need it; and
- Success in their relationships with peers and significant adults.

Though early secure attachment is believed by many to be crucial to ongoing normal development in later stages, consistency of attachment is also important. Trust can be lost if attachment is not maintained. Attachments may also become more secure if parents or other caregivers are able to improve their parenting and show more positive emotion in their interactions with their children.

It is also important to recognize that, in some cultures, children have more caregivers, or are parented more by siblings or grandparents, for example, than by parents. These children may form more attachments or may form primary attachments, not to parents, but to other people. When multiple attachments are a cultural and social norm, you would expect to see children easily moving between adult caregivers.

LANGUAGE DEVELOPMENT

Language development is crucial to the development of higher-level thinking, reasoning, and memory processes. Language gives us a way to experience and manipulate our world through symbols. For example, language gives children a way to express emotions without physically acting them out, and a way to relate to and learn from others’ thoughts and feelings (Fahlberg, 1991.)

Children learn language in the social context—by hearing others use words and word combinations and connecting these with things, happenings, and other kinds of meaning. Words are symbols.

Attentive parents or other caregivers help babies learn to talk in several ways: by talking with them, especially slowly and distinctly, and as if they could understand whatever is being said; by talking about what children are looking at or doing; and by playing games with them that involve words and taking turns, as in conversation (for example, pat-a-cake.)

Exposure to speech helps children learn to speak. More specifically, ways to help children learn to speak are **labeling** (identifying the names of objects,) **echoing** (repeating what the child says,) and **expanding** or **recasting** (restating what the child has said, but in a more sophisticated form.)

Babies with normal hearing prepare for language development by beginning to coo around 2 months and to babble around 6 months. They add consonants and syllables to the coos from 6 to 14 months and, on average, by 7 months are making some sounds of mature spoken language.

From 6 to 9 months, children begin to understand words, or have a **receptive vocabulary**. They say their first words around 12 months, on average. These are usually words that name important people (mama, dada,) objects (car,) or animals (doggie,) or words that convey greetings or leave-takings (hi, bye-bye.)

Once the child speaks his/her first word, the **spoken vocabulary** grows rapidly. Between 18 and 24 months, it may grow from about 50 words to as many as 300 words.

At 20 to 26 months, children start making two-word combinations that mean something (**telegraphic speech**.) By the end of the second year, most children are making simple sentences. From 2 to 3 years into the school years, they are learning to make complex sentences. Parents can help by encouraging younger children to make whole sentences.

Children have to learn many things in learning language: word meanings and shades of meanings; pronunciations; word combinations and arrangements; sentence structure; nonverbal accompaniments to spoken language; tone of voice; acceptable volume in various situations; and adapting speech to make meaning clear to a variety of people.

Among the impediments to learning language are isolation, lack of response to attempts to speak, and disabilities, such as deafness.

Culture plays a big part in how children learn languages. For example, in a large, extended family that interacts regularly, a child is likely to be exposed to more talk and may learn more words faster than a child who interacts with only one parent. Also, when the language spoken at home is different from the language of the culture in which a family lives, children in the family may have a harder time learning the culture's language.

Gender also plays a role in language development, particularly at young ages. Research has shown (Feingold 1992, 1993) that although both boys and girls appear to comprehend language equally well, girls tend to produce language at earlier ages. As infants, girls produce more sounds at an earlier age, use words sooner, and have larger vocabularies than boys. Usage of standard grammar also proceeds more rapidly for toddler girls. This advantage in language production for girls gradually diminishes until, by late adolescence, boys catch up.

Depending on age, children may not:

- Remember what day of the week something happened (“Did Mommy leave on Monday or was it Tuesday?”)
- Understand sequence expressed as *before* and *after* (“Did Tommy hit you before he took the cookie?”)
- Understand the difference between *the* and *a*, and understand *more/less* and *some/all* comparisons.
- Understand *do you remember* questions.
- Be able to decipher embedded ideas (“Did the boy who hit you take your cookie?”)
- Understand the passive voice (“Were you hit by Janie?”)

BRAIN DEVELOPMENT

Brain development begins in the third to fourth week after conception. By the end of the second trimester, the child has more than 100 billion neurons, or nerve cells—all that he or she will ever have. After birth, these neurons form connections, or synapses, in response to outside stimulation. Learning occurs through these connections. Much of the brain’s growth and development occurs during the first few years after birth. By age 3, a baby’s brain is approximately 90% of its adult size. Thus, early stimulation and interaction with the world are critical to determining the person we become.

Earlier thinking about children and how they learn viewed them as unreasoning beings who simply took in what was going on around them in infancy without being able to make sense of it until sometime later. More recent research on brain development has shown that this is not the case. In fact, children are reasoning beings even in the early months of life. They take in and assimilate information and experience, acquiring knowledge about the world and skills to function in it.

From more recent brain research we know that:

- There are “windows of opportunity” for acquiring specific kinds of skills and information, times when a part of the brain can pick up and use this new material more easily than other times. (For example, children are best able to acquire music and math skills from 1 to 5 years of age.)
- Acquiring skills or information at these prime times helps future development occur in the best possible time and way.
- Learning (acquiring information and skills and knowing how to use them) occurs through a combination of things, including genetics, interaction with and response from others, and other environmental stimulation.

Interactions with others and the environment help the child keep certain brain cell connections and discard others. Connections that are used over and over form the basis of the child’s brain organization and function. This is why stimulation and outside opportunities for experience are important.

However, some experts believe that our new knowledge about critical learning periods has led to excessive concern, resulting, in some cases, in pushing young children too hard into learning situations (e.g., David Elkind, “The Hurried Child.”) Over stimulation can be harmful, just as under stimulation can, perhaps leading to burnout and emotional stress at a young age.

The brain continues to develop throughout life to adapt to experience. This makes it possible for individuals to continue learning and, in some cases, to reverse the damage from periods of sensory

deprivation. From what we know now, though, it is far better for a child to get optimal care and stimulation for brain development early in life.

What children need in the first three years to achieve their highest potential:

- Good maternal health during the prenatal period;
- A feeling of safety;
- Belief that their needs will be met;
- A feeling of importance to others;
- A balance of freedom and limits; and
- Exposure to appropriate and diverse experiences involving, for example, toys, music, books, playmates, parents, and other adults.

EMOTIONAL INTELLIGENCE

Recently, there has been significant work on the concept of **emotional intelligence**. Daniel Goleman, a chief reporter of and spokesperson for this work, describes it generally by saying that IQ alone is not the most important thing for success. Rather, emotional intelligence, or understanding and managing one's feelings wisely, is more important. Some examples are:

- Being able to identify and talk about one's feelings, such as anxiety and anger, and to see how these direct thoughts and behaviors;
- Being able to control or redirect feelings to avoid fights or other dysfunctional behaviors;
- Knowing how to get along with other people despite differences;
- Being able to control one's negative impulses and to delay gratification for a better future outcome;
- Being assertive rather than passive;
- Negotiating rather than fighting;
- Taking responsibility for one's actions;
- Following through on commitments; and
- Having an objective view of one's positive and negative traits, and liking oneself despite recognized imperfections.

Thanks largely to Goleman's work, emotional intelligence is being taught in some schools to help children develop and use emotional competence in dealing positively with personal problems and with differences between themselves and others.

Foundations

In this curriculum, we highlight a few theorists whose work has been important in child and adolescent development. They are important because they laid the foundations for current developmental theory and knowledge and, frequently, what they researched and wrote still has practical value and is widely used today. A general familiarity with the names and ideas of these thinkers should be a part of your understanding of developmental issues for children and adolescents.

The first theorist treated here is Abraham Maslow. His **hierarchy of needs** still forms a good framework for developmental issues throughout the life span. Following Maslow there is some information on Sigmund Freud and his work on **psychosexual development**. Next is Erik Erikson, whose more comprehensive **psychosocial theory** divides the entire life span into stages, each with a specific developmental challenge and task. Also included are Jean Piaget, whose work on **cognitive-developmental theory** describes a universal pattern of learning to think logically, and Lawrence Kohlberg, who built on Piaget's theory to outline **stages of moral reasoning**.

To a large extent, these early theorists made their observations on middle- to upper-class individuals who were more or less alike culturally. In some cases, they conducted their studies solely on males and formed their ideas from a male perspective. Later thinkers challenged and expanded much of their work beyond its narrow gender, cultural, and racial focus. There was also a growing awareness of how profoundly human development and functioning were influenced by environmental or ecological factors beyond the strictly cultural. These changes in knowledge and perspective led to more inclusive and comprehensive studies, some of which have radically changed our thinking.

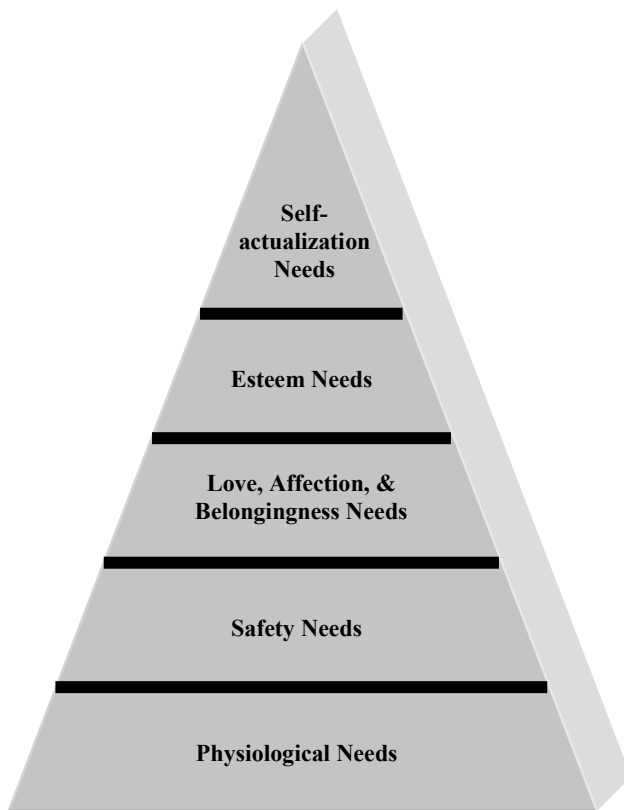
The following sketches present both the thinking of the seminal theorists and the challenges posed to it by later theorists. Brain development and emotional intelligence, two important areas of recent study and writing related to human development, have been treated earlier in this Resource Book.



ABRAHAM H. MASLOW (1908-1970)

Abraham Maslow was a psychologist who taught at Brooklyn College and Brandeis University. He is best known for his work in human motivation theory, which led to a therapeutic technique called **self-actualization**. Often, when we talk about Maslow, we talk about his **hierarchy of needs**. This refers to our need to have our most basic requirements met before we can proceed to concentrate on higher needs. The hierarchy is a listing of these needs, from the most basic up to the highest, self-actualization. This concept is useful in considering human development throughout the life span. Since childhood is the foundation for the rest of life, Maslow's hierarchy can be particularly helpful as a framework for considering what a child needs for optimum growth and development.

Maslow's hierarchy is depicted in the following pyramid:



SIGMUND FREUD (1856-1939)

Sigmund Freud, a Czech neurologist who practiced primarily in Vienna, is known as the father of psychoanalysis and is associated with the psychosexual perspective on personality development. In Freud's view, human behavior and psychological functioning were motivated by two basic drives: **sexuality and aggression**. In his theory, there are five stages through which individuals pass in psychological growth and development, each centered on sexual impulses. These stages are oral, anal, phallic, latency, and genital. In developing through the five stages, Freud held, children progress from instinctual behavior, centered on getting the most basic needs met, to mature sexuality that is best expressed in a loving relationship with a partner.

Freud also conceptualized the personality as having three parts:

- The **id**, which exists from birth and is most prominent in the newborn baby, is the subconscious part. It is related to the individual's most basic needs and wants, such as the desire for food.
- The **ego** is the rational, conscious part. It begins to emerge later in infancy and helps the child relate to the realities of the environment and the constraints imposed by others, without losing a healthy concept of self. For example, a young child cannot always be fed exactly when hunger strikes, but most older toddlers who are well cared for will learn to wait a reasonable time for food, without losing trust that their hunger will be satisfied.

- The **superego** can be thought of as something like the conscience. Ideally, it acts as a guide to behavior. It is associated with morality. It is the ego's job to mediate between the demands of the id, which can be ruthless if allowed free rein, and those of the superego, which can be overly harsh and restraining. A typical adolescent struggle between id and superego might, for example, revolve around the issue of sex. While the basic desire for sex would come from the id, the superego might produce feelings of guilt. It would be the ego's job to consider both sides and resolve the dilemma. The individual who progresses ideally through the stages of development will have a healthy ego that helps him or her interact well with others and with the environment, while maintaining a sound sense of self. To attain such ego function, the individual needs appropriate support and guidance from caregivers.

Much of Freud's theory has been challenged by later thinkers, partly because it grew out of a male perspective and was generalized to women, in some ways harmfully. Karen Horney, Nancy Chodorow, and Carol Gilligan, among other writers, have refuted Freud's male-biased theory with a positive model of female development and strength that builds on relationships. Freud's theory also drew heavily on the memories of upper-class adults in a generally repressed period, rather than on work with children, whose development it purports to outline. Today, too, it is apparent that Freud neglected the importance of sociocultural influences and, by concentrating solely on early childhood experience, the importance of later experience to development. Nevertheless, his work with disturbed clients formed the basis of our "talking" therapies and some aspects of his theories (e.g., the triadic personality) are still foundations for understanding human behavior.



ERIK ERIKSON (1902-1994)

Erik Erikson was a German-born analyst who learned not only from Freud's work, but also from his study of Sioux and Yurok Indians in the United States, where he spent much of his adult life as a teacher and clinical practitioner. Building on Freud's psychosexual theory, Erikson drew a broader and more positive picture of what ideally should happen in each stage of development. In his work on what came to be called **psychosocial theory**, Erikson not only put sexual and aggressive impulses into a larger context, but also added adult stages to the course of development, thus becoming one of the first to view character formation as lifelong work.

In each developmental stage, Erikson said, a central conflict, or **psychosocial crisis**, must be faced and new skills acquired in the process. The more able an individual is to resolve the crisis successfully, the more likely he or she is to experience healthy development in the future. His stages follow the **epigenetic principle**, according to which a biologically ordered plan must be followed systematically for an individual to develop fully. In Erikson's view, a whole lifetime is necessary for the complete integration of the various aspects of psychosocial functioning. Crucial to success in the earlier stages are adequate support and guidance from caregivers. Somewhat like Freud's thinking, Erikson's envisions the accomplishment of the developmental tasks as generally a matter of learning to balance personal needs against those of society.

Erikson describes the following eight stages:

1. **Trust vs. Mistrust** (from birth to 12 months): The infant forms a loving, trusting relationship with a caregiver, which, in turn, forms the foundation for the expectation of the world as a secure and pleasant place to live. If this stage is not negotiated successfully, the infant may be mistrustful, fearful, and anxious about the future.

2. **Autonomy vs. Shame** (1-3 years): Infants and toddlers begin to explore their world and assert their independence. Unsuccessful resolution of this stage may lead to feelings of shame and self-doubt.
3. **Initiative vs. Guilt** (3-6 years): The preschooler needs to rely on active, purposeful behavior more and more as their environment presents new challenges and demands more responsibility. Successfully coping with new challenges leads to a sense of accomplishment. Children may develop guilt if they are too assertive, irresponsible, or made to feel too anxious.
4. **Industry vs. Inferiority** (6-12 years): The school age child must learn to deal with demands to learn a wide range of new skills, including the tasks of formal schooling. If he or she is unable to learn these skills, it can lead to feelings of failure and incompetence.
5. **Identity vs. Role Confusion** (12-18 years): The primary task at this developmental stage is the formation of a sense of personal identity with regard to such things as opinions (e.g., on politics and religion,) sexual roles, and occupation. Failure to successfully negotiate this stage may result in over identification with peers' or parents' opinions and confusion over goals or sex roles.
6. **Intimacy vs. Isolation** (young adulthood): At this stage, individuals face the task of forming intimate relationships with others. If the individual is successful, he or she is able to form healthy friendships and intimate relationships with others. If not, social and emotional isolation could result.
7. **Generativity vs. Stagnation** (middle adulthood): The focus of this stage is on parenting. By generativity, Erikson means helping the next generation to develop and lead useful lives. The feeling of having done little or nothing to help develop and support the next generation is stagnation.
8. **Integrity vs. Despair** (late adulthood): If the individual has been successful in resolving the crises associated with earlier stages, when he or she looks back on his or her life, it will be with a feeling of satisfaction and fulfillment. Erikson describes this as a feeling of integrity. If earlier crises have not been resolved positively, looking back is likely to lead to feelings of despair.

Like Freud's work, Erikson's has been criticized for its Eurocentric male focus and has been expanded upon by subsequent theorists. Margaret Mahler and others stressed the need for a symbiotic relationship between the infant and the mother as the basis of the child's later separation-individuation, the process of acquiring an awareness of the self as a separate and distinct entity apart from the parent. Barbara M. Newman and Philip R. Newman expanded on Erikson's stages, coming up with a total of ten that they believe more accurately reflect life today.

Perhaps the most sweeping challenge to Erikson's theory has come from such writers as Chodorow and Gilligan, among others. Women do not fit the pattern of finding identity apart from others, some of these writers believe, but rather develop identity in relation to others; generally, women value emotional ties more than men, who tend to strive for autonomy as their paths to individuality. Similarly, some writers say that the stages of development occur in a different order for men and women. That is, for men, identity formation comes before intimacy; for women, on the other hand, intimacy comes first.

Despite all the arguments surrounding Erikson's theory and the useful amendments that have been made to it, it is still widely used, sometimes with one or more of these amendments, as a framework for the study of human development.



JEAN PIAGET (1896-1980)

Jean Piaget, a Swiss researcher who was trained as a biologist and naturalist, became interested first in children's reasoning processes and later in their moral development, judgment about ordinary happenings, and language. For his work with children, he is associated with **cognitive developmental theory**, which describes a universal pattern of learning to think logically.

In this developmental process Piaget posited four stages:

- **Sensorimotor Intelligence**—birth to 18 months, characterized by the infant's taking in the world only through the senses; for example, sucking on, shaking, or throwing toys in order to explore them. During this stage, infants develop the concept "object permanence," in which they begin to understand that just because they can't see something, it doesn't mean it's gone. This is the beginning of the development of memory.
- **Preoperational Thought**—first use of language to 5 or 6 years old, characterized by the development of language and the use of symbolism and make-believe. Children's thought at this age is egocentric, meaning that they do not yet understand that other people may have different thoughts, feelings, and knowledge than they do. For example, children at this age often tell stories that don't proceed in the type of logical sequence an adult would expect, and leave out information that they assume everyone knows because they know it. Children at this age understand that words are symbols for real objects, people, animals, etc., and can pretend (e.g., use a box for a car, or checkers for cookies.) They have an understanding of past and future, although they don't have an adult understanding of time concepts or cause and effect. Preoperational children typically do not understand things in terms of more than one dimension or relationship. For example, they typically will not understand when you say, "Grandma is my mommy," or may say things like, "I don't live in the USA, I live in Pennsylvania."
- **Concrete Operational Thought**—from 6 or 7, to 11 or 12, when logic comes into play and helps in categorization of objects and ideas. Children at this age can begin to problem solve, but problem solving is based on concrete experience, and children need to understand new concepts through the use of familiar examples. Children in the stage of concrete operations begin to understand conservation concepts (e.g., that the water in a tall, skinny container can be the same amount as the water in a short, fat container, even though they look different.) They also begin to be able to think reversibly.
- **Formal Operational Thought**—adolescence through adulthood, marked by the capacity for abstract thought and complex problem solving. Individuals at this stage can problem solve using symbols and abstract ideas without having to experience first hand (e.g., solve mathematical equations, or understand the effects of the earth's rotation on the seasons in the northern and southern hemispheres.) During this stage, individuals can also understand multiple viewpoints that may differ from their own and consider hypothetical "what ifs."

Piaget believed that individuals learn through an ongoing process of **assimilation**, or taking new information into their existing body of knowledge, and **accommodation**, by which they adjust to and use their new knowledge.

Piaget posited his theories about cognitive development primarily on observations of his own three children. Since that time, it has become possible to do more systematic and scientific studies of children. Some of these studies have challenged Piaget's theories, especially on cognitive development in infancy. More recent research shows that, rather than merely taking in through the senses what happens around them, infants learn, remember, and organize events into coherent patterns from a very early age. Research is continuing on all aspects of cognitive development. How, and how early, children learn the skills that prepare them for the stages ahead is currently one of the hottest topics in brain research, and has filtered down into the popular literature as well, fueling what today appears to be an industry in products and programs designed to help parents give their infants a head start on success. In turn, this movement has produced a backlash of concern about the potentially detrimental effects such parental over stimulation could have on children's lives (e.g., Elkind, "The Hurried Child.")



LAWRENCE KOHLBERG (1927-1987)

Lawrence Kohlberg, a psychologist who was born in Bronxville, New York, taught for many years at Harvard. His theory of moral development builds on the work of Jean Piaget. Piaget believed that children are born without a moral consciousness, but from the ages of four to seven, roughly, develop the first stage of morality, in which they see justice and rules of behavior as fixed in the grand scheme of things, beyond any human control. In the second stage, which many children have reached by ten or so, they see rules and laws as made by humans and somewhat flexible, depending on the intent of those who may break them.

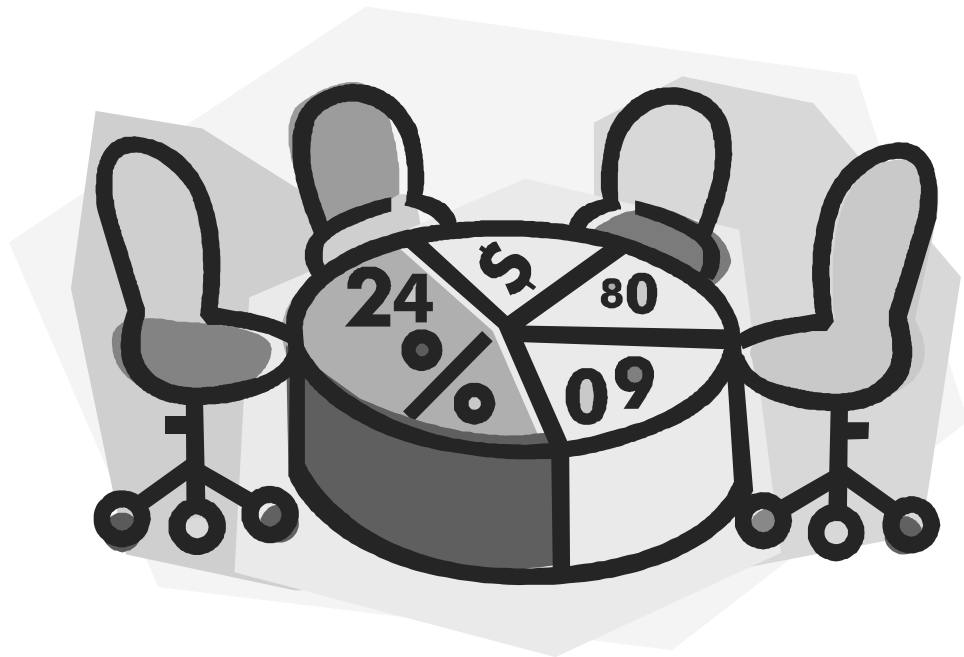
Kohlberg believed that moral development depended on moral reasoning and was learned in three levels, each having two stages. The levels are:

- **Preconventional Reasoning**—moral reasoning directed initially by the expectation of punishment from external sources, and later by an interest in personal reward;
- **Conventional Reasoning**—initially to get approval, and later in response to law and a sense of duty; and
- **Postconventional Reasoning**—moral reasoning guided by community versus individual rights, and later by universal principles of ethics.

Kohlberg thought that most people never progress beyond the middle level.

Kohlberg's theory has been criticized for emphasizing moral thought more than moral behavior; for cultural bias (his Western definition of justice does not carry across all cultures;) for a perceived lack of reliability and validity in study methodology; and for its failure to consider strongly enough the role of family and culture in the development of moral reasoning. Gilligan, who was Kohlberg's student at Harvard, has also criticized his **justice perspective** as a male-oriented view and offered as a feminist counterpart the **care perspective**, which views moral development in terms, not of individual rights, but rather of people's connectedness with others. The care perspective emphasizes relationship with and concern for others as the context of moral development. Not all feminist writers agree with Gilligan, however. Some find that qualities of both perspectives exist in both males and females to varying extents, and that the two perspectives are not mutually exclusive.

Tables & Charts



Fetal Development

0 THROUGH 8 WEEKS

This outline counts fetal development from the moment of fertilization. Gestational age is calculated from a woman's last menstrual cycle and adds two weeks to the ages given.

Nervous System

- week 3**— Neural plate forms and will develop into nervous system.
- week 4**— Cerebral cortex and vertebrae begin to form. Brain forms and begins rapid growth.

Limbs

- week 4**— Buds that will become limbs have formed.
- week 5**— Hands begin to develop. Nerves grow into limb buds.
- week 6**— Elbows form, fingers begin to develop, and feet begin to form.
- week 7**— Toes begin to form.
- week 8**— Fingers and toes have separated.

Respiratory System

- week 4**— Lung buds begin to develop, and bronchial tubes are forming.

Digestive System

- week 3**— A tube develops that will become intestines, liver, pancreas, and bladder.
- week 4**— A primitive stomach is in place.
- week 5**— Liver begins rapid growth.

Eyes, Ears, & Mouth

- week 4**— Eyes, ears, and mouth begin to form.
- week 5**— Eyes have retina and lens.
- week 6**— Tip of nose appears, teeth begin to form, and upper lip is formed. Eyes and ears begin movement to their normal positions.
- week 7**— Eyelids are forming.

Heart & Circulatory System

- week 2**— Primitive placental circulation begins. Embryo receives nourishment from the mother.
- week 3**— The heart and primitive circulatory system begin to rapidly form and function.
- week 4**— First heart beats can be detected.
- week 5**— Blood cells are produced by the liver.
- week 8**— The heart has almost completely formed.

Skeletal & Muscular Systems

- week 5**— Cartilage and bones begin to form. Muscles for the skeletal system begin to form.
- week 6**— Joints begin to form, and trunk begins to straighten.

Urinary & Genital Systems

- week 5**— Permanent kidneys begin to form.
- week 8**— Testes and ovaries are distinguishable.

9 THROUGH 38 WEEKS

After about the tenth week of development, exposure to teratogens, or agents likely to be harmful to the developing baby (e.g., caffeine, alcohol, drugs,) is more likely to impair organ functioning rather than cause major physical abnormalities. From 28 to 38 weeks, the fetus gains most of its weight. A baby is considered full term when he/she is born 38 weeks after fertilization.

Nervous System

- week 10**— The brain's basic divisions are complete.
- week 15**— Reflexes begin to function (sucking and swallowing.)
- week 23**— Spinal column is forming.
- week 24**— All of the brain's neurons are formed, and brain activity begins for visual and auditory systems.
- week 27**— Fetus is sensitive to light, sound, taste, and smell.
- week 29**— Brain undergoes another period of rapid development.
- week 35**— Hearing is fully developed.
- week 36**— Increased central nervous system control over body functions.

Limbs

- week 12**— The hands are becoming functional.
- week 15**— Fat begins to form under the skin.
- week 16**— Pads form on fingertips and toes.
- week 32**— Fingernails are completely formed.

Respiratory System

- week 9**— Lungs make breathing movements.
- week 24**— Lungs' air sacs are developing and have good blood flow.
- week 28**— Respiratory system can be considered viable.
- week 35**— Lungs are fully developed.

Digestive System

- week 10**— Pancreas secretes insulin.
- week 11**— Intestines have moved from umbilical cord to stomach.
- week 12**— Liver secretes bile.
- week 35**— Liver begins to process waste products.

Eyes, Ears, & Mouth

- week 9**— Iris begins to form, and the eye has its basic structure.
- week 9**— Palate begins to fuse.
- week 11**— Vocal cords form.
- week 12**— Fusion of palate is complete.
- week 14**— Eyes and ears are almost in their final positions.
- week 20**— Eyelids are formed and fused shut.
- week 21**— Middle ear bones begin to harden.
- week 26**— Eyes are completely formed and partially open.
- week 34**— Baby begins to blink—can differentiate light and dark.
- week 37**— Baby has hair.

Heart & Circulatory System

- week 9**— The placenta is fully functioning.
- week 15**— The heart pumps several quarts of blood daily.
- week 38**— Heart is fully developed.

Skeletal & Muscular Systems

- week 10**— Connections between nerves and muscles increase.
- week 28**— Bone marrow produces red blood cells.
- week 33**— Bones are hardening; skull is still pliable and not completely joined.

Urinary & Genital Systems

- week 9**— Kidneys are functioning.
- week 12**— Gender is clearly distinguishable by external genitalia.
- week 20**— Uterus begins to develop.
- week 28**— Testes begin to descend to scrotum.
- week 35**— Kidneys are fully developed.

How to Use the Growth Charts

On the following pages, there are two types of growth charts. One type shows percentiles for height, or length, and weight. The second shows percentiles for head circumference and for height and weight considered together. There are separate charts for boys and girls, and for birth through age 2 (up to 36 months,) and age 2 through 19.

To use them, locate the correct chart for the gender and age range of the child using the heading at the top of the page.

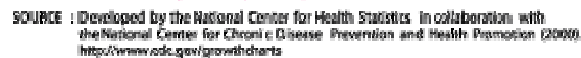
Charts covering height and weight are divided into two sections, with height on top and weight on the bottom (for infants and toddlers, height is expressed as length.) To locate the child's percentile rank, find the child's height in inches along the left or right side of the chart and the child's age in months or years along the top of chart, and then follow the grid lines to where they meet. The curved lines labeled 5, 10, 25, 50, 75, 90, and 95 indicate the 5th, 10th, 25th, 50th, 75th, 90th, and 95th percentiles. Percentile ranks indicate the percentage of children who are at or below a particular height or weight. For example, a percentile rank of 75 for height indicates that the child is taller than 75% of children his or her age in the general population. The closer to the 50th percentile the child is, the closer to average he or she is.

The charts for head circumference are used in the same way. Locate the child's head circumference in inches along the sides of the chart and the child's age along the top. The point where the lines intersect is the child's percentile rank.

The lower portions of the head circumference charts show percentile ranks for height and weight considered together. Locate the child's weight along either the right or left side of the chart and height along the bottom. The point where the lines meet is the percentile rank for that combination of height and weight. Note: It is possible that a child who is in the 90th percentile for weight to be considered average, rather than heavy, if his or her height is also around the 90th percentile. Children who are proportional will fall around the 50th percentile on these charts.

LENGTH & WEIGHT

NAME _____



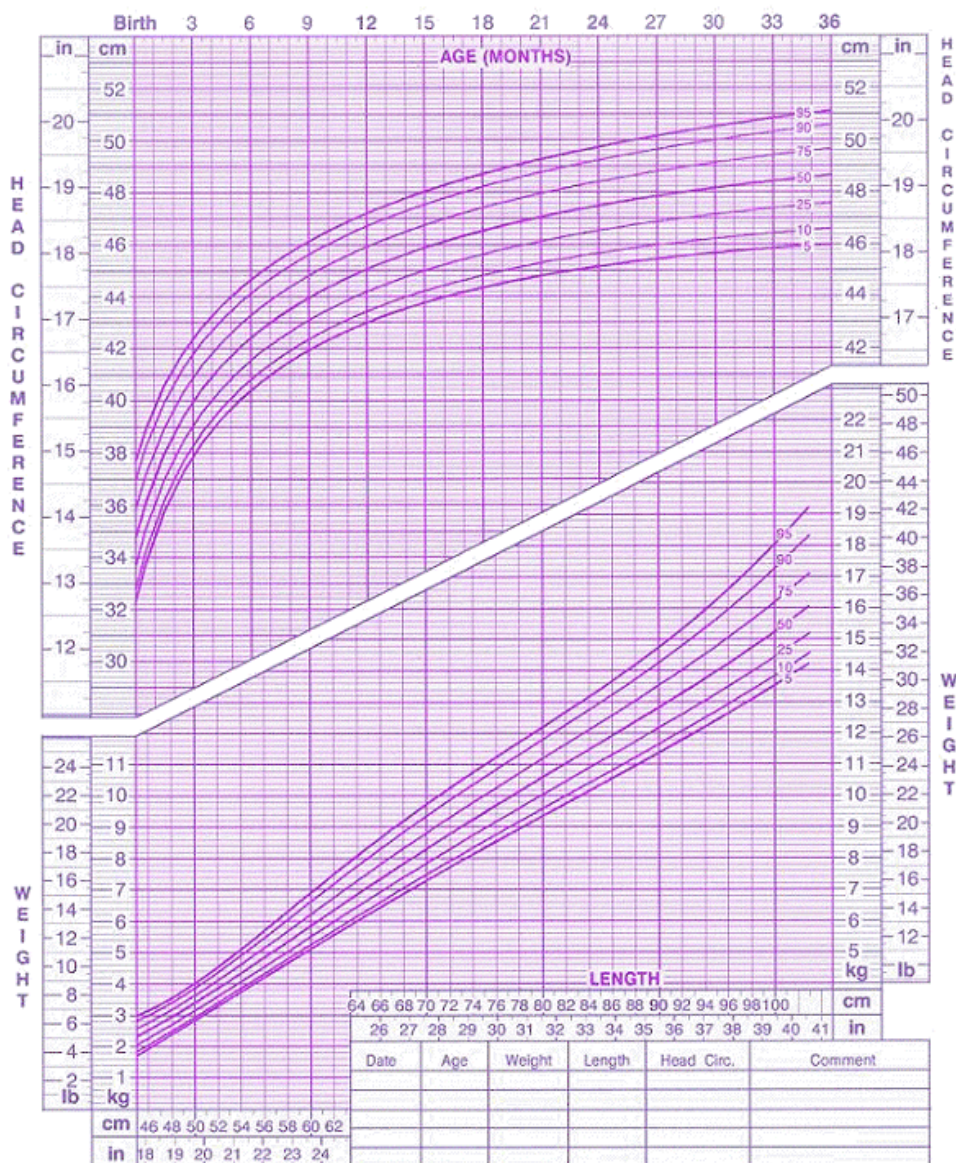
HEAD CIRCUMFERENCE

Small head circumference at birth can be an indicator of poor prenatal development and possible exposure to teratogens. More than slow height and weight gain, poor development in head circumference can indicate developmental problems or child neglect.

WHAT YOU NEED TO KNOW
About Parenting Babies & Toddlers
babyparenting.about.com

Birth to 36 months: Girls
Head circumference-for-age and
Weight-for-length percentiles

NAME _____



Published May 30, 2000 (modified 10/16/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with
the National Center for Chronic Disease Prevention and Health Promotion (2000).
<http://www.cdc.gov/growthcharts>



SAFER • HEALTHIER • PEOPLE™

Growth Charts—Boys (0 through 2)

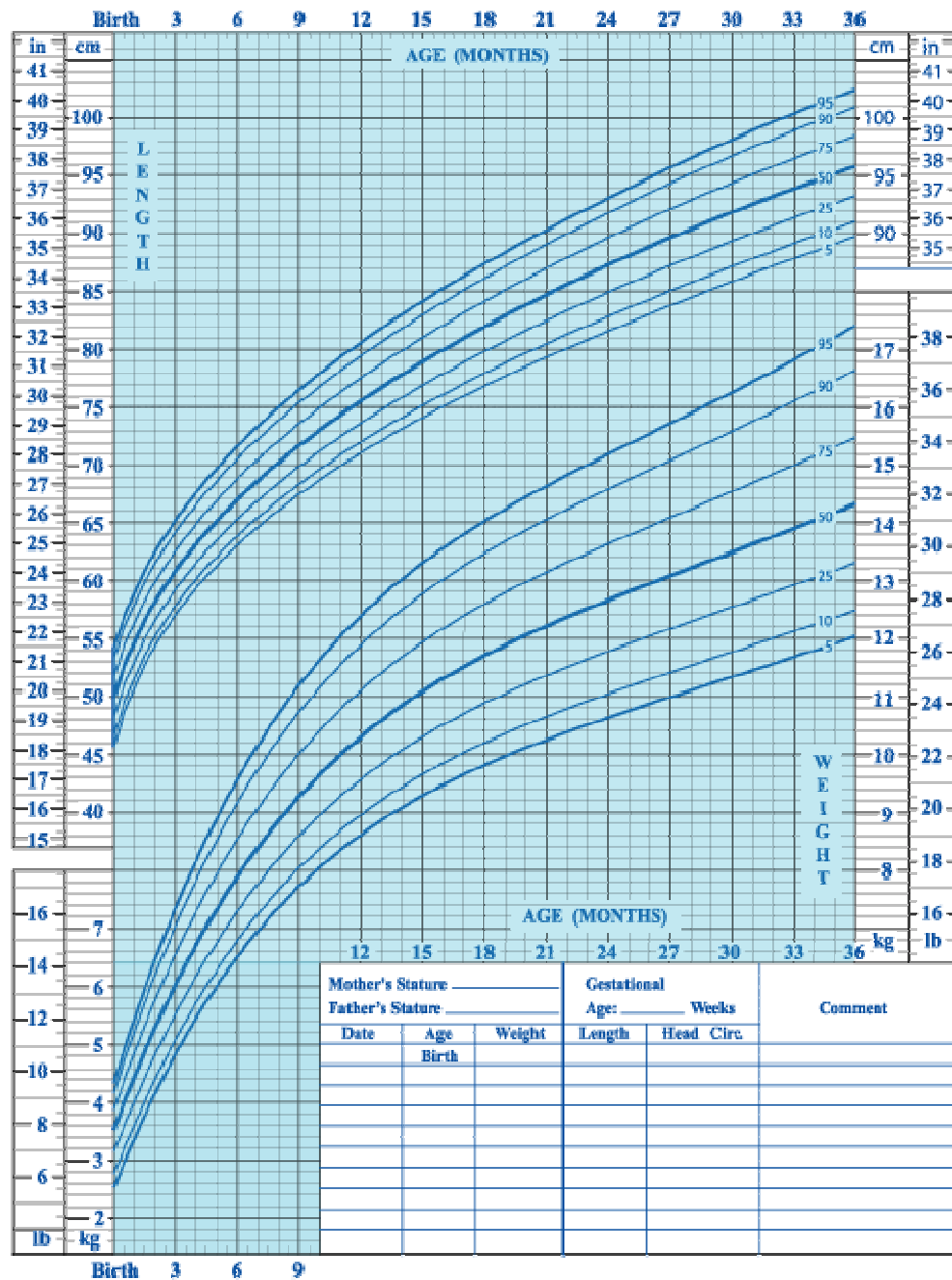
LENGTH & WEIGHT

Birth to 36 months: Boys

Length-for-age and Weight-for-age percentiles

About Pediatrics

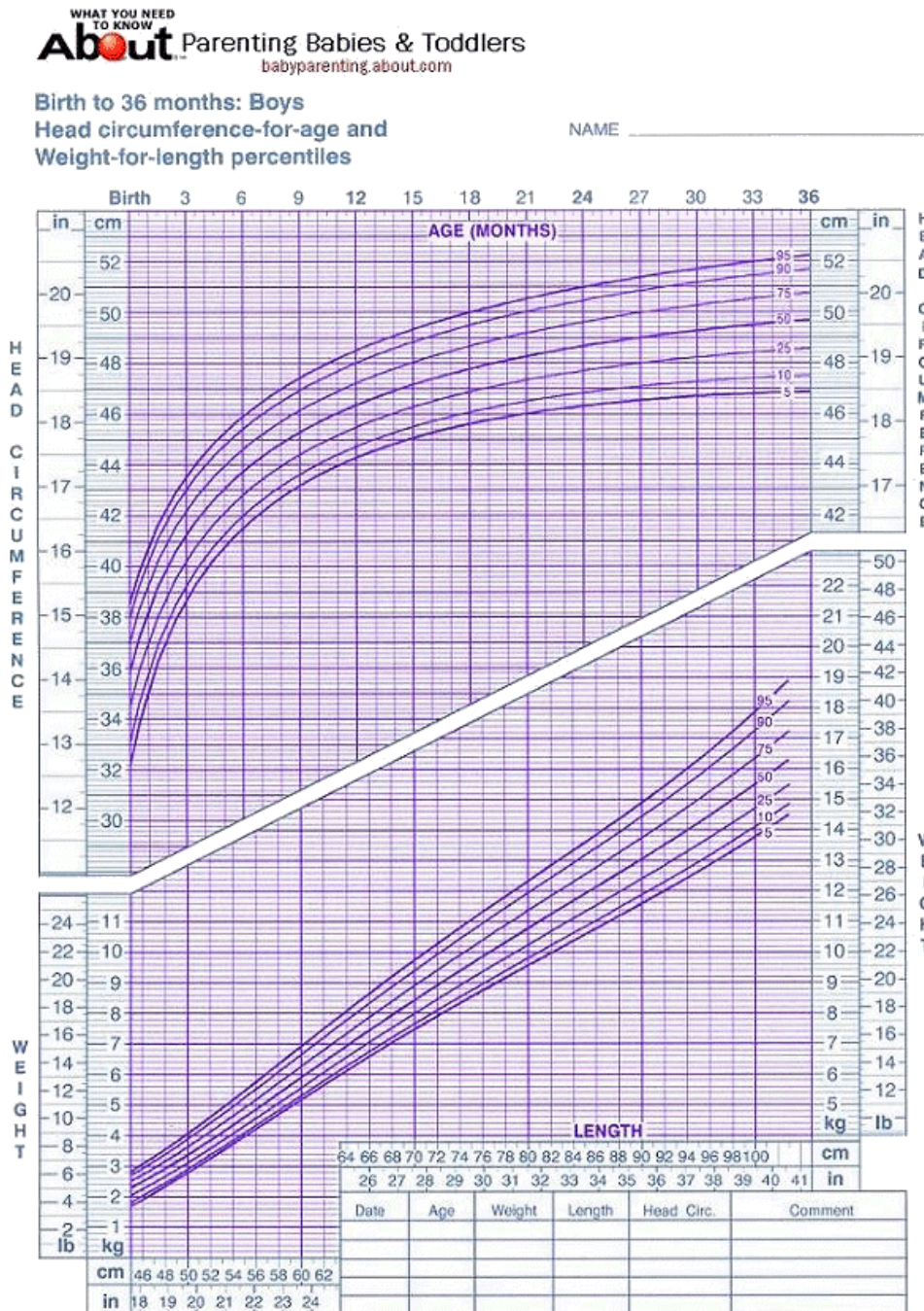
NAME _____



SOURCE : Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000). <http://www.cdc.gov/growthcharts>

HEAD CIRCUMFERENCE

Small head circumference at birth can be an indicator of poor prenatal development and possible exposure to teratogens. More than slow height and weight gain, poor development in head circumference can indicate developmental problems or child neglect.



Published May 30, 2000 (modified 10/16/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with
the National Center for Chronic Disease Prevention and Health Promotion (2000).
<http://www.cdc.gov/growthcharts>

CDC
SAFER • HEALTHIER • PEOPLE™

Growth Charts—Girls (2 through 19)

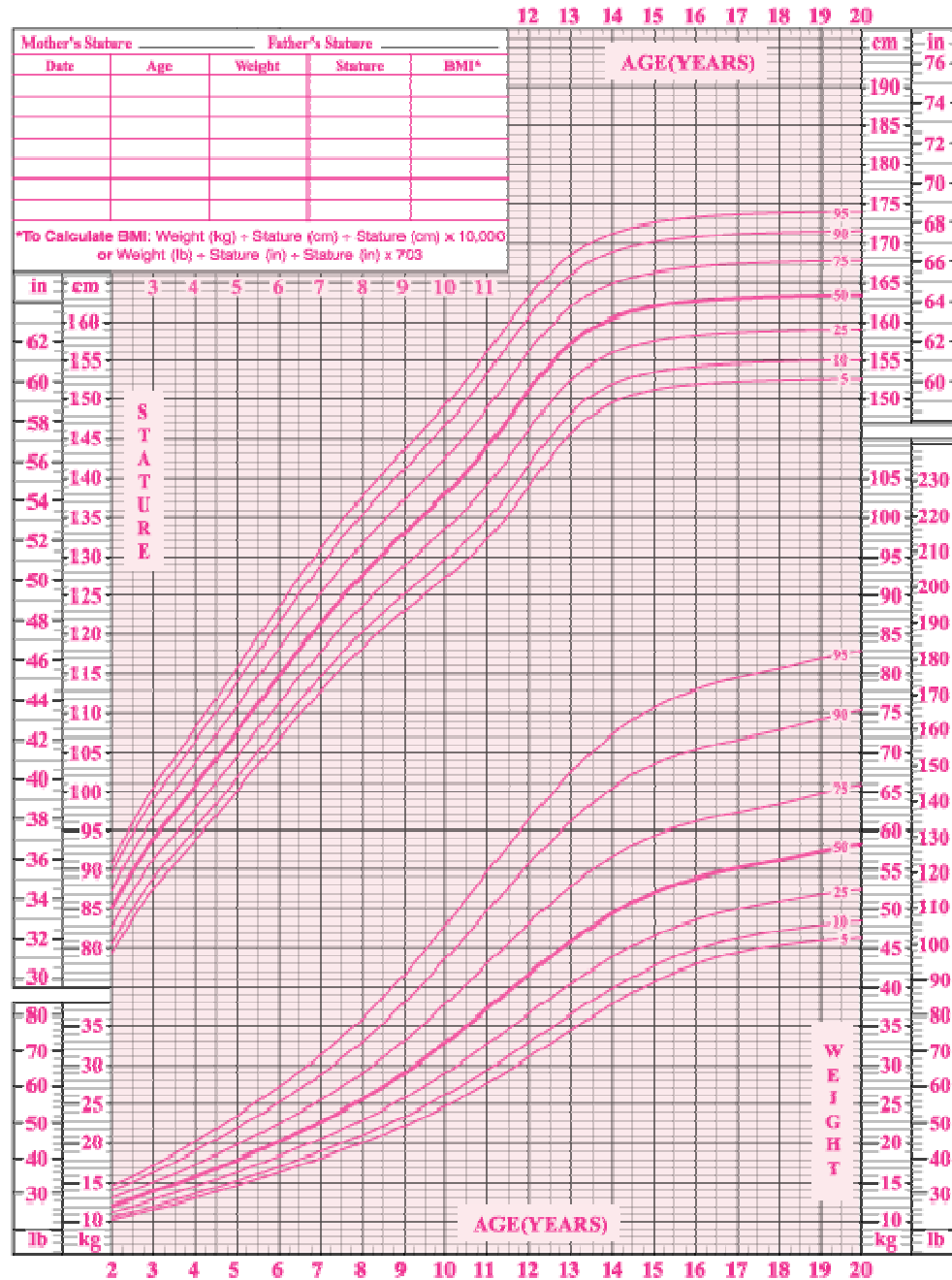
HEIGHT & WEIGHT

About Pediatrics

2 to 20 years: Girls

Stature-for-age and Weight-for-age percentiles

NAME _____



SOURCE : Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
<https://www.cdc.gov/growthcharts>

Growth Charts—Boys (2 through 19)

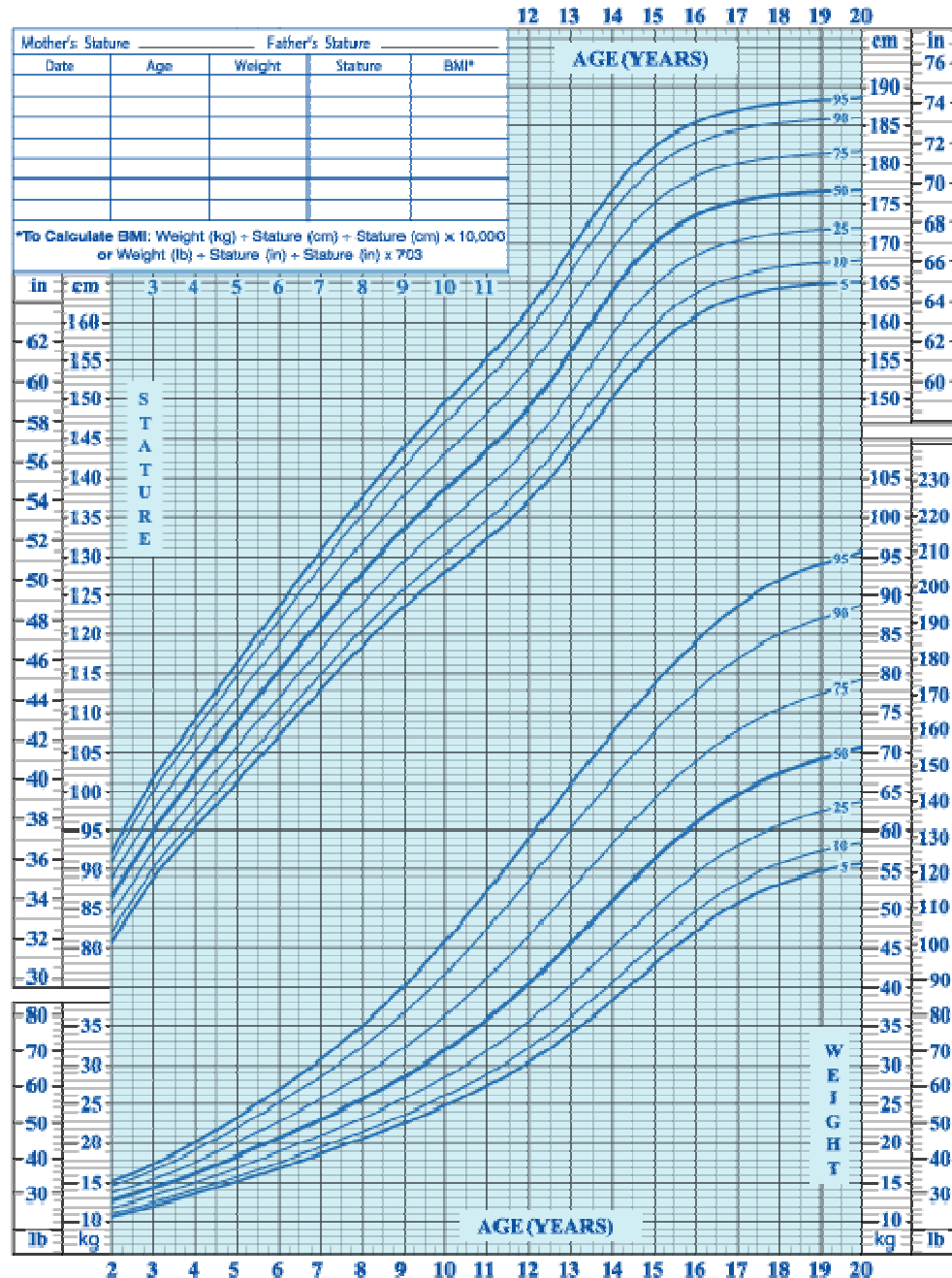
HEIGHT & WEIGHT

About Pediatrics

2 to 20 years: Boys

Stature-for-age and Weight-for-age percentiles

NAME _____



SOURCE : Developed by the National Center for Health Statistics, in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
<http://www.cdc.gov/growthcharts>

Tables of Developmental Characteristics and Markers

The following tables have been designed for use in this training and in your work with children and families. The form on page 33 is similar to the one used in training, but has been modified to allow photocopying and use at work.

GUIDELINE FOR COMPLETING THE OBSERVATION NOTES

1. Give a brief description of the behaviors or characteristics you've observed in the child.
2. Is it in the normal range? Check the developmental tables to determine whether the child's behavior or characteristic is on target. Remember, variations of a few weeks to a few months before and after what is considered the normal time for an individual to display developmental characteristics may be considered within the normal range. There is no hard and fast rule about how much variation is normal, but, in general, the amount of normal variation increases with age of the child. For infants, variations of a few weeks to a month may be completely within normal limits. For older children, variations of up to 6 months before or after a suggested milestone date may be considered normal.
3. How did you arrive at your conclusion?
4. Describe the caregiver or environmental supports that contribute to this normal or below normal development. Your notes on this item might lead to suggestions for encouraging the child's development. See Suggested Resources for sources of ideas for encouraging development.

HOW TO USE THE TABLES

The tables are divided into five headings at each of six stages of child and adolescent development. Each heading represents a domain, or specific sphere of growth and development, containing a set of common characteristics. The three major domains considered in this training are physical, cognitive/linguistic, and socioemotional. Language and moral development, which are considered as part of the cognitive and socioemotional domains, are listed separately in the tables to highlight their importance.

The physical domain covers growth and maturational processes, fine motor skills (skills that enable the child voluntarily to reach objects and to grasp, hold, and transfer them from hand to hand,) and gross motor skills (skills that enable the child to move around the environment efficiently, such as crawling, standing, and walking.)

The cognitive domain covers growth in an individual's capacity to reason, remember, and learn. The development of language is included here because the ability to represent the world symbolically through words is intimately related to the ability to think abstractly, encode and store experience as memories, and learn without having to have direct concrete experience of an event or concept. (For example, we can learn about the effects on the body of space flight by reading without becoming astronauts.)

The socioemotional domain is concerned with the development of social and interpersonal skills and understandings (e.g., empathy and morality,) as well as the child's growing ability to understand and regulate his or her emotions.

Different writers may divide domains somewhat differently—for instance, treating moral development or language development as separate domains rather than a part of socioemotional or cognitive development,

or breaking physical development into gross motor and fine motor areas. But however it is presented, the information is essentially the same.

For each stage of development, there are milestones, or attainments, that tell whether or not the individual has achieved typical, or “normal,” development in the domains (e.g., learning to walk at about 12 months, or use a spoon around age 2.) More broadly, there are developmental tasks that each individual needs to complete for each major developmental stage in each domain before he or she can proceed with optimum hope for success to the next stage. A task may be thought of as a function that must be accomplished by the individual as part of growth and development (e.g., learning to walk.) Accomplishing a developmental task enables the individual to take on still more complex tasks. Under each of the five main headings is a list of milestones and tasks typically achieved at that age. Following the lists of tasks and milestones are lists of “red flags” that may signal concerns, and tips for promoting healthy development at that stage.



Observation Notes

PHYSICAL DEVELOPMENT

Behavior or characteristics: _____

Normal range? ☐ yes ☐ no

Basis for conclusion: _____

Describe the caregiver or environmental factors that contribute to this normal or below normal development: _____

COGNITIVE DEVELOPMENT (INCLUDE LANGUAGE NOTES HERE)

Behavior or characteristics: _____

Normal range? ☐ yes ☐ no

Basis for conclusion: _____

Describe the caregiver or environmental factors that contribute to this normal or below normal development: _____

SOCIOEMOTIONAL DEVELOPMENT (INCLUDE MORAL DEVELOPMENT HERE)

Behavior or characteristics: _____

Normal range? ☐ yes ☐ no

Basis for conclusion: _____

Describe the caregiver or environmental factors that contribute to this normal or below normal development: _____

Infancy (0 to 12 Months)

BIRTH TO 6 MONTHS

Physical

- Rapid height and weight gain
- Strong reflexes (e.g., sucking, grasping) beginning at birth, and random movements gradually becoming more directed and purposeful (by 3 months)
- Sleep organized into a day and night schedule (by 1-3 months)
- Lifts head up (by 1-3 months)
- Rolls over from stomach to back (by 3 months)
- Reaches for objects (by 4-6 months)
- Responds to both a specific stimulus and the environment (by 1 month)
- Comfortable with routine stimuli; uncomfortable with new stimuli
- Hearing well developed; displays sensitivity to sounds of own language (by 1-3 months)
- Eyes work together to perceive stimuli as organized patterns; can judge distance of objects in reaching for them (by 1-3 months)
- Prefers pattern of human face over other patterns
- Grasps objects (by 1-3 months)

Cognitive

- From birth, infant begins to “learn” with eyes, ears, hands, etc.

- Repeats chance behaviors leading to pleasurable and interesting results (e.g., accidentally hits a swinging doll, likes the movement, and hits it again)
- Reaching, grasping, and manipulating objects turn baby’s attention to outside world (by 4-6 months)
- Has recognition memory for people, places, and objects (by 6 months)
- Forms perceptual categories based on objects’ similar features (by 6 months)

Language

- Coos and babbles (by 1-3 months)
- Chuckles and gurgles (by 1-3 months)
- Joins with caregiver in paying attention to labeling objects and events (by 4-6 months)

Socioemotional

- Infant forms attachment to primary caregivers, which is the foundation for future socioemotional and moral development
- Prefers primary caregiver to stranger (by 1-3 months)
- Smiles in response to caregiver’s voice (by 1 month)
- Shows almost all basic emotions (by 1-3 months)
- Smiles and laughs socially (by 4-6 months)
- Cries to signal needs (food, water, comfort) and begins to acquire trust when needs are met (by 1 month)
- Begins to distinguish own image in mirror from others’ images (by 6 months)
- Startles to loud noises or loss of support (e.g., when caregiver moves a supporting hand) (by 1-3 months)

Moral

- Egocentric; no moral concept
- Groundwork for moral development being laid in tension between dependence on larger, powerful others and experience of having needs met; having needs met leads to trust and attachment

Indicators of Concern (Birth to 6 Months)

- Sucks poorly and feeds slowly (by 1 month)
- Doesn't blink when shown a bright light (by 1 month)
- Doesn't focus and follow a nearby object moving side to side (by 1 month)
- Rarely moves arms and legs; seems excessively loose in the limbs or floppy (by 1 month)
- Seems very stiff, with tight muscles, or trembling/involuntary movements (by 1 month)
- Doesn't respond to loud sounds (0-1 month)
- Doesn't notice his hands (by 2 months)
- Doesn't smile at the sound of primary caretaker's voice (by 2 months)
- Doesn't follow moving objects with his eyes (by 2-3 months)
- Doesn't grasp and hold objects (by 3 months)
- Doesn't smile in response to people (by 3 months)
- Cannot support his head well (by 3 months)
- Doesn't babble (by 3-4 months)
- Doesn't reach for or grasp toys (by 3-4 months)
- Has trouble moving one or both eyes in all directions, or crosses eyes (by 3 months)
- Doesn't pay attention to new faces, or seems very frightened by new faces or surroundings (by 3 months)
- Still has Moro reflex (spasms and extends limbs to sudden shifts in head, then brings arms together and cries loudly) (after 4 months)
- Doesn't bring objects to his mouth (by 4 months)
- Begins babbling, but doesn't try to imitate any of caretakers' sounds (by 4 months)
- Doesn't push down with his legs when his feet are placed on a firm surface (by 4 months)
- Head still flops back when body is pulled up to a sitting position (by 4 months)
- Still has the tonic neck reflex (when head is turned in one direction, baby extends same side arm and flexes the opposite) (at 4-5 months)
- Reaches with one hand only (by 4 months)
- Refuses to cuddle (by 4 months)
- Shows no affection for the person who cares for him (by 4 months)
- Doesn't seem to enjoy being around people (by 4 months)
- One or both eyes consistently turned in or out (by 4 months)
- Persistent tearing, eye drainage, or sensitivity to light (by 4 months)
- Doesn't seem to respond to sounds around him (by 4 months)
- Does not turn his head to locate sounds (by 4 months)
- Doesn't roll over in either direction (front to back or back to front) (at 5 months)
- Seems inconsolable at night (after 5 months)
- Doesn't smile spontaneously (by 5 months)
- Cannot sit with help (by 6 months)
- Does not laugh or make squealing sounds (by 6 months)
- Does not actively reach for objects (by 6-7 months)

6 TO 12 MONTHS

Physical

- Sits alone (by 6 months)
- Crawls, pulls up, and walks with support (9-12 months)
- Shows refined grasping ability (by 6 months)
- Brings objects to mouth (by 6 months)
- Understands more complex speech, such as phrases, short sentences
- By 12 months, has 3-D perception and can distinguish objects from their surroundings by shape, color, and texture
- Baby teeth begin to emerge
- Feeds self finger foods; holds own bottle (by 6-9 months)

Cognitive

- Engages in goal-directed behavior (9-12 months)
- Has recall memory for people, places, and objects (9-12 months)
- Finds objects hidden repeatedly in one place, but not when moved (by 6 months)
- Imitates adults' actions with objects
- By end of stage, begins to understand physical causality (e.g., things fall without support)
- Plays peek-a-boo (recognizes that hidden objects are still there) (by 9 months)

Language

- Imitates speech sounds (6-9 months—may be earlier for girls than boys)
- Says “mama” or “dada” (9-12 months—may be earlier for girls than boys)
- Beginning to understand words; has a receptive vocabulary (9-12 months)
- Uses preverbal gestures to communicate (by 12 months)

Socioemotional

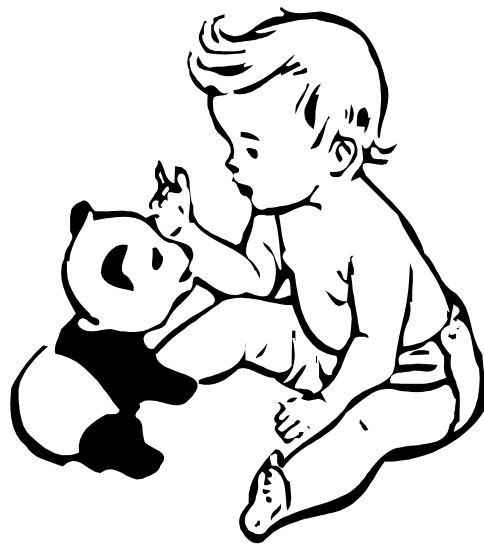
- Responsive care giving encourages secure attachment; infant then can use caregiver as a secure base from which to explore
- Stranger anxiety and separation anxiety appear with secure attachment; child welcomes return of person to whom attached (by 6-9 months)
- Repeats performances for attention (by 9-12 months)

Moral

- Continues to be egocentric; no moral concept
- Groundwork for moral development continues to be laid in tension between dependence on larger, powerful others and experience of having needs met; having needs met leads to trust and attachment
- Sharp discipline, scolding, and verbal persuasion are not helpful; discipline consists of redirecting to different activity

Indicators of Concern (6 to 12 Months)

- Does not crawl (by 12 months)
 - Drags one side of body while crawling (for over one month)
 - Cannot stand when supported (by 12 months)
 - Does not search for objects that are hidden while he watches (by 9 months)
 - Says no single words (“mama” or “dada”) (by 12 months)
 - Does not learn to use gestures, such as waving or shaking head (by 12 months)
- Does not point to objects or pictures (by 12 months)
 - Does not follow objects with both eyes at near (one foot) and far (six feet) ranges (by 7 months)
 - Does not try to attract attention through actions (by 7 months)
 - Does not babble (by 8 months)
 - Shows no interest in peek-a-boo (by 8 months)



Toddlerhood (12 to 36 Months)

12 TO 18 MONTHS

Physical

- Height and weight gain rapid, but not as great as in first year
- Walks alone (12-18 months)
- Manipulates small objects with improved coordination (12-15 months)
- Begins to be able to drink from a cup and use a spoon (15-18 months)
- Feeds self with fingers (12-15 months)
- Builds tower of 2 blocks (12-18 months)
- Removes hat, socks, and shoes (12-15 months)

Cognitive

- Experiments with objects, trial-and-error fashion (e.g., drops, throws, bangs, shakes) (12 months)
- Looks for dropped or hidden objects (12 months)
- Looks in appropriate place when asked (e.g., “Where’s the book?”) (12-15 months)
- Sorts toys and other objects into groups (by 18 months)
- Match shapes in a busy box (12-15 months)
- Sustained attention improves

Language

- Actively takes turns in games, such as pat-a-cake and peek-a-boo (by 12 months)
- Says first words (e.g., mama, dada, doggie, bye-bye) (12-13 months); has 3-5 word spoken vocabulary (may be earlier for girls than boys)
- Understands the word “no” (12-15 months)
- Vocalizes “no” (15-18 months)
- Communicates by gestures (12-15 months)
- Points to pictures of common objects (15-18 months)

18 TO 24 MONTHS

Physical

- Jumps, runs, and climbs
- Manipulates small objects
- Helps dress and undress self
- Makes tower of 4 blocks

Cognitive

- Develops language, use of make-believe, and symbolism; beginning at 2, going to 7, cognitive development moves into a reliance on personal perceptions of the environment and egocentric thought
- Searches for objects when they have been moved while out of sight
- Imitates actions of an adult; tries to produce same effect, even if not fully able
- Engages in make-believe play
- Sorts objects into categories more effectively
- Recall memory for people, places, and objects improves

Language

- Spoken vocabulary increases rapidly to 200-300 words (may be more rapid for girls)
- Begins to make two-word combinations that mean something (may be earlier for girls than boys)
- By age 2, makes simple sentences (combines 2-3 words; may be earlier for girls than boys)
- Starts to use words to influence a playmate’s behavior
- Likes to name objects and pictures of objects
- Refers to self by name
- Uses “me” and “mine”

Socioemotional

- Joins in play with familiar adults and siblings (by 12 months)
- Recognizes image of self in mirrors (by 12 months)
- Shows signs of empathy (e.g., may comfort hurt playmates) (by 12 months)
- Complies with simple commands (15-18 months)
- Solitary or parallel play (15-18 months)
- Claiming of “mine” (15-18 months)
- Fears heights, separation, strangers, and surprise (12-18 months)

Moral

- Experience in having needs met by powerful others continues to lay groundwork for moral development
- Experience with being reprimanded signals misdeed; child’s sense of right and wrong comes from early caregiver responses
- Sharp discipline, scolding, and verbal persuasion are not helpful; discipline consists of redirecting to different activity

Socioemotional

- Tasks are separation (movement away from mother) and individuation (development of the self,) as in exploring out of parent’s sight, though returning to be sure parent is still there
- Secure attachment aids healthy separation and individuation
- Begins to tolerate caregiver’s absences more easily
- Shows gender-stereotyped toy choices
- Self-control begins
- Toilet training begins
- Solitary or parallel play continues
- Mimics real life situations during play (e.g., rocks a baby doll)
- Pulls person to show

Moral

- By age 2, may begin to distinguish intentional or deliberate behavior from accidental behavior (e.g., may announce an action one is going to perform)
- Experiences negative emotion with misdeed (disapproval by parent)

24 TO 36 MONTHS

Physical

- Slower gains in height and weight than in toddlerhood
- Appetite usually increases
- Learns to run, jump, hop, throw overhand, and catch
- Puts on and removes some items of clothing
- Uses spoon effectively
- Shows signs of coordination and aggression

Cognitive

- Development of language; use of make-believe and symbolism; has personal perceptions of the environment and egocentric thought
- Make-believe becomes less dependent on toys, less self-centered, and more complex
- Aware of the difference between inner mental and outer physical events
- Follows 2-step commands
- Attention span is short; dawdling through tasks is common

Language

- Vocabulary increases rapidly (about 300 words; may be more rapid with girls)
- Sentences become more complex (3-4 word sentences) and follow word order of native language (may be earlier for girls than boys)
- Calls self by first name (up to about 30 months)
- Begins to use the word "I" (about 30 months)



Indicators of Concerns (12 to 24 Months)

- | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none">• Cannot walk (by 18 months)• Fails to develop a mature heel-toe walking pattern after several months of walking, or walks exclusively on his toes• Does not speak at least 15 words (by 18 months)• Does not use two-word sentences (by age 2) | <ul style="list-style-type: none">• Does not seem to know the function of common household objects (brush, telephone, bell, fork, spoon) (by 15 months)• Does not imitate actions or words (by age 2)• Does not follow simple instructions (by age 2)• Cannot push a wheeled toy (by age 2) |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Socioemotional

- Distinguishes his own intentional from unintentional acts
- Understands causes and consequences
- Empathy increases
- Gender-stereotyped beliefs and behavior increase
- When the child perceives someone as “good” in one aspect, will assume that person is “good” in every way

Moral

- Has a concept of “right” vs. “wrong” based on personal wants and statements heard from adults (e.g., may take a desired toy from another child and say, “you have to share”)
- Can learn, with guidance, how one’s negative behavior affects another and begin to modify behavior accordingly, which supports the continuing development of empathy
- Responds to discipline and instruction that fit personal temperament (e.g., a shy child is overwhelmed and shamed by an overly stern scolding)



Indicators of Concern (24 to 36 Months)

- | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none">• Cannot run, jump, or hop• Cannot use a spoon to feed him or herself• Does not put on and remove some items of clothing• Does not speak in simple sentences that use normal word order• Does not imitate adults and playmates• Does not enjoy make-believe games | <ul style="list-style-type: none">• Does not spontaneously show affection for familiar playmates• Cannot take turns in games• Does not understand concept of “mine” and “his/her”• Does not express affection openly• Does not express a wide range of emotions• Does not separate easily from parents (by 3)• Does not object to major changes in routine |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Early Childhood (3 to 6 Years)

3 TO 4 YEARS

Physical

- May no longer need daytime nap
- Continues to run, jump, throw, and catch with better coordination
- Begins to gallop and to skip on one foot
- Rides tricycle
- Uses scissors
- Scribbles become pictures; draws first picture of a person, and can tell the difference between own writing and non-writing
- Can button and lace
- Can use toilet or potty chair and stay dry during the day
- Eats and dresses by himself with supervision

Cognitive

- Continuing language development, make-believe, personal perceptions of the environment, and egocentric thought
- Wants answers to many questions
- Understands causality in familiar situations
- Understands models and simple maps as symbols
- Uses private speech (talks to self) to guide behavior in challenging tasks
- Attention becomes more sustained and playful
- Dawdling through tasks is still common
- Listens to stories eagerly
- Counts up to small numbers
- Can recognize some geometric shapes and letters of the alphabet
- Understands color names

Language

- Masters increasingly complex grammatical structures (e.g., understands and begins to use prepositions)
- Understands many culturally accepted ways of adjusting speech to fit the age, sex, and social status of speakers and listeners
- Has a vocabulary of 1500 words (by 4)
- Can answer simple questions
- Can give first and last name
- Understands opposite analogies (e.g., hot-cold)

Socioemotional

- Begins to distinguish other people's intentional acts from unintentional acts
- Emotional self-regulation improves
- Understands taking turns and sharing
- Self-conscious emotions become more common
- Playing alone declines, and interactive play increases
- Forms first friendships
- Shows preference for same sex playmates
- Fears noises, imaginary creatures, punishment, dogs, small animals, storms, the supernatural, and loss of parents

Moral

- Though behavior is tied mainly to avoiding punishment and getting rewards, still continues to form a sense of justice and altruism through experiences, observations, and instruction; seeing how powerful others respond to events helps child form ideas on right, wrong, and appropriate behavior
- First moral reasoning for behavior is to avoid punishment and later is to attain rewards



5 YEARS

Physical

- Body is streamlined and longer legged with proportions similar to those of adult
- Gets first permanent tooth
- Gross motor skills increase in speed and endurance; skipping on both feet appears
- Can hop on one foot
- Fine motor skills increase (ties shoes; draws more complex pictures; writes name)
- Can visually discriminate fine-grained visual forms such as letters of the alphabet
- Dresses self
- Washes face; brushes teeth

Cognitive

- Attends kindergarten or Head Start
- Continuing language development, make-believe, personal perceptions of the environment, and egocentric thought
- Ability to distinguish appearance from reality improves
- Attention continues to improve
- Dawdling through tasks is still common
- Recall memory, memory for routine or repeated behavior, and memory of important events all improve
- Understands that letters and sounds are linked in systematic ways
- Engages in simple addition and subtraction (e.g., $2 + 2 = 4$)
- Beginning sense of time (e.g., understands today, yesterday, tomorrow, and about how long an hour is)

Language

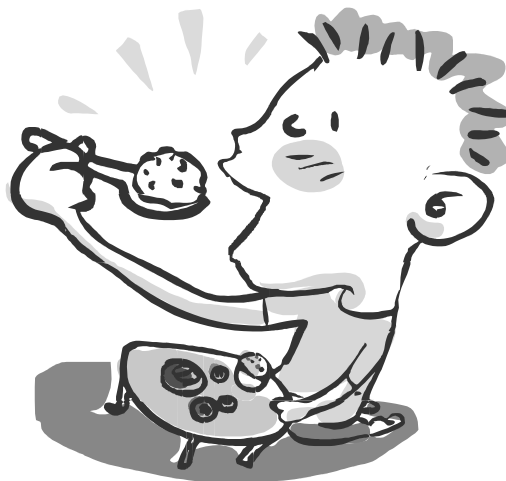
- Vocabulary reaches about 10,000 words (girls earlier than boys)
- Uses many complex grammatical forms (e.g., “Grammy’s sad, isn’t she?” and “I think it’s Billy’s birthday”) (girls earlier than boys)
- Understands and uses adverbs, prepositions, comparative terms (e.g., big, bigger, biggest) (girls earlier than boys)
- Can follow two- or three-stage command
- Understands opposite analogies
- Enjoys “funny” sounding words and humor
- Articulates all consonant sounds; infantile pronunciations disappear (girls earlier than boys)
- Uses questions to understand and conceptualize

Socioemotional

- Shows better social awareness of people's intentions
- Ability to predict, interpret, and influence others' emotional reactions improves
- Relies on language to express empathy
- Gender-stereotyped beliefs and behavior continue to increase
- Grasps the genital basis of sex differences and understands that gender remains fixed
- Begins cooperative group play
- Dogmatic
- Can be aggressive, bossy
- May assert self and argue with parents' wishes
- Unreasonable fears are common

Moral

- Has a sense of reciprocity (e.g., sharing) as a social obligation, but is still more concerned with "what's in it for me"
- Does what adults say to avoid trouble
- Has acquired, at least as part of a basis for further moral development, many ideas and "rules" based on culture (e.g., in some Asian families, reverence for elders)



Indicators of Concern (Early Childhood)

By age 3:

- Cannot throw a ball overhand
- Cannot jump in place
- Cannot ride a tricycle
- Cannot grasp a crayon between thumb and fingers
- Has difficulty scribbling
- Cannot stack four blocks
- Still clings or cries whenever his parents leave him
- Shows no interest in interactive games
- Ignores other children
- Doesn't respond to people outside the family
- Doesn't engage in fantasy play
- Resists dressing, sleeping, or using the toilet
- Lashes out without any self-control when angry or upset
- Cannot copy a circle
- Doesn't use sentences of more than three words
- Doesn't use "me" and "you" appropriately

By age 6:

- Exhibits fearful or timid behavior
- Exhibits extremely aggressive behavior
- Is easily distracted and unable to concentrate on any single activity for more than five minutes
- Shows little interest in playing with other children
- Refuses to respond to people in general, or responds only superficially
- Rarely uses fantasy or imitation in play
- Seems unhappy or sad much of the time
- Doesn't engage in a variety of activities
- Avoids or seems aloof with other children and adults
- Doesn't express a wide range of emotions
- Has trouble eating, sleeping, or using the toilet
- Can't differentiate between fantasy and reality
- Seems unusually passive
- Cannot understand two-part commands using prepositions (e.g., "put the cup on the table" or "get the ball under the couch")
- Can't correctly give his first and last name
- Doesn't use plurals or past tense properly when speaking
- Doesn't talk about his daily activities and experiences
- Cannot build a tower to six or eight blocks
- Seems uncomfortable holding a crayon
- Has trouble taking off clothing
- Cannot brush his teeth efficiently
- Cannot wash and dry his hands

Middle Childhood (6 to 11 Years)

6 TO 9 YEARS

Physical

- Slow gains in height continue
- Gradual replacement of primary teeth by permanent teeth throughout middle childhood
- Fine motor skills:
 - ◆ Writing becomes smaller and more legible
 - ◆ Drawings become more organized and detailed and start to include some depth
- Gross motor skills:
 - ◆ Can dress and undress alone
 - ◆ Organized games with rough-and-tumble play becoming more common

Cognitive

- Attends first through third grades
- Thought becomes more logical, helping the child categorize objects and ideas
- Can focus on more than one characteristic of concrete objects
- Attention becomes more selective and adaptable
- Can use rehearsal and organization as memory strategies
- Becomes more aware of the importance of memory strategies in task performance
- In writing, letter reversals decline
- Mastering more complex mathematics skills
- Emotional intelligence is developing:
 - ◆ Self-awareness, understanding of own feelings
 - ◆ Empathy for the feelings of others
 - ◆ Regulation of emotion
 - ◆ Delaying gratification

Language

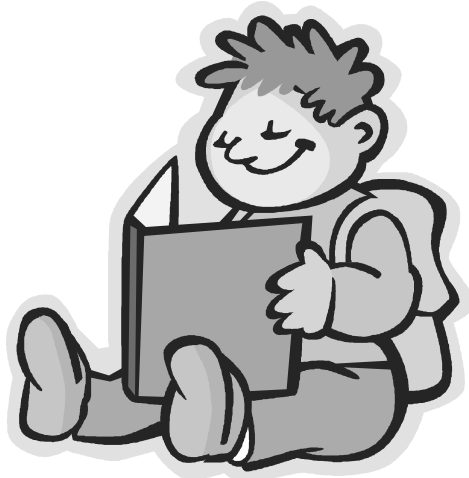
- Talks freely and is still interested in new words
- Communicates in clear and complete sentences
- Asks many purposeful questions (when, how, why)
- Beginning to read (age 6)
- By the end of this period, makes the transition from “learning to read” to “reading to learn”
- Can give full name, age, sex, home address, and usually birthday
- Talks about home possessions; often reveals family secrets
- Carries on long conversations
- Enjoys riddles and simple jokes
- May use bathroom language
- Vocabulary increases rapidly throughout middle childhood
- Word definitions are concrete, referring to functions and appearance

Socioemotional

- May have a special friend
- Likes action on television
- Enjoys books and stories
- May argue with other children, but shows cooperation in play with a particular friend
- Self-concept includes identifying own personality traits and comparing self with others
- Self-conscious emotions of pride and guilt are governed by sense of personal responsibility and accomplishment
- Recognizes that individuals can experience more than one emotion at a time
- Attends to more cues (facial, situational, and memory of past experience) in interpreting another's feelings
- Understands that different people can have different perspectives
- Becomes more responsible and independent
- Learns social problem solving as ideas on fairness and justice grow more complex

Moral

- Still obeys adults to avoid trouble
- Beginning to understand the need for rules and fair play
- Has more objective ideas about fairness than before, especially in terms of "same" or "equal" treatment (e.g., "if Bobby gets one, I should have one, too" and vice versa)
- Around 6 or 7, also connects fairness with merit (e.g., "Kesha worked hard, so she deserves the award")
- Around 8, understands the concept of benevolence (e.g., "it's okay for Kim to get a head start in the race because she has a limp and can't run as fast")
- Can adapt ideas about fairness to fit varied situations



9 TO 11 YEARS

Physical

- Girls' adolescent growth spurt begins
- Gross motor skills are better coordinated (running, jumping, throwing and catching, kicking, batting, and dribbling)
- Reaction time improves, which contributes to motor skill development
- Fine motor skills improve; depth cues evident in drawings through diagonal placement, overlapping objects, and converging lines

Cognitive

- Attends fourth and fifth grades
- Planning improves
- Continues to improve in using rehearsal and organization as memory strategies
- Can apply several memory strategies at once
- Can learn memory strategy of elaboration (creating a link between unrelated items to help in remembering them)
- Long-term knowledge base grows in size and organization
- Improves in cognitive self-regulation (monitoring and directing progress toward a goal), but still may dawdle, appear disorganized
- Emotional intelligence is developing:
 - ◆ Self-awareness, understanding of own feelings
 - ◆ Empathy for the feelings of others
 - ◆ Regulation of emotion
 - ◆ Delaying gratification
- Thought continuing to be more logical; getting better at categorizing objects and ideas

Language

- Grasps double meanings of words as reflected in comprehension of metaphors and humor
- Understanding of complex grammatical constructions improves
- Adapts messages to the needs of listeners in situations of complex communication
- Conversational strategies become more refined

Socioemotional

- Self-esteem rises (top dog of childhood now)
- Distinguishes between effort and luck as causes of successes and failures; can become critical of others quickly
- Has adaptive set of strategies for regulating emotion
- Empathy continues to improve
- Can view relationships between self and others objectively
- Understands the linkage between moral rules and social conventions
- Peer groups emerge
- Friendships are based on the pleasure of sharing through activities or time spent together
- Becomes aware of more gender stereotypes, including those involving personality traits and academic disciplines, but has a more flexible appreciation of what males and females can do
- Sibling rivalry tends to increase

Moral

- From resolving peer disagreements, sees others' perspectives and incorporates broadened view into growing concept of right and wrong, fair and unfair
- Though concerned with approval, rewards, and self-interest, generally growing less me-centered and more pro-social



Indicators of Concern (Middle Childhood)

- Low self-esteem
- Acts sad much of the time
- Acts nervous much of the time
- Aggressive much of the time (hits, fights, curses, breaks or throws objects)
- Exhibits poor control over impulses
- Has difficulty concentrating or sitting still
- Scapegoated or ignored by other children
- Poor grades
- Does not respond to positive attention and praise
- Seeks adult approval and attention excessively
- Suspicious and mistrustful of adults; does not turn to adults for help or comfort
- Little frustration tolerance; difficult to engage and keep interested in goal directed activity
- Cannot adapt behavior to different social settings
- Does not show different role expectations for boys and girls (e.g., “Barbie is for girls”)
- Does not engage in rule-governed play (sports, board games)
- Does not have “best friend” and group of same sex friends
- Does not use knowledge of past events and consequences to plan future actions
- Does not understand that a person’s identity remains the same regardless of outward changes (e.g., costume)
- Cannot understand concepts of space, time, and dimension (e.g., first, next, last, or telling a story in order)
- Can’t differentiate real from pretend (e.g., insists an imaginary friend is real)
- Can’t recognize similarities and differences in or classify concrete objects
- Can’t understand the difference between behavior and intent (breaking a lamp is equally bad regardless of whether on purpose or an accident)

Early Adolescence (11 to 15)

Physical

- Period of rapid skeletal and sexual maturation
- Preoccupation with body image
- Girls' adolescent growth spurt begins at 10½ years on average; menarche occurs on average around 12½ years (but changes can begin as late as 15½ years)*
- Early-maturing girls are more vulnerable to problems such as smoking, drinking, depression, eating disorders, negative self-image, isolation, submissive behavior, and less popularity
- Boys' adolescent growth spurt begins around age 12½; early maturation positive for boys at this age (but changes can begin as late as 15½ years)
- Pubic hair develops, followed by auxiliary hair (earlier for girls than boys)
- For boys, voice begins to lower; mustache hair may begin to grow in
- There is wide variation in beginning and completion of puberty
- Physical effects of puberty on development in other domains not as great as once thought; depends on social and cognitive factors

Cognitive

- Attends sixth through ninth grades
- Thinking is less concrete, more abstract, idealistic, and logical; hypothetical-deductive reasoning, complex problem solving, and critical thinking emerge
- Increased interest in ideas, values, and social issues, often with narrow understanding and dogmatic opinions
- Interprets personality of others (uses previous information, detects situational variation in behavior, and looks for deeper, more complex causes of personality)
- Intense interest in music, clothes, hair, and personal appearance (especially for girls)
- Social cognition:
 - ◆ Belief in an imaginary audience, that others are as preoccupied with one as oneself is (e.g., "everyone is looking at me")
 - ◆ Personal fable—belief in personal uniqueness (e.g., "no one understands me") and belief that self is invulnerable ("I won't get hurt")
- Able to understand others points of view, but tends to be egocentric
- Greater attention span and ability to focus
- Wants to do well in activities and in school, although may mask with feigned indifference
- Ethnic minority youth learn how to negotiate two systems—their own culture and the dominant culture

* Most textbooks use these ages as the norm, although the latest information indicates these changes may occur a good deal earlier.

Language

- May not like to communicate with adults
- May question adult authority and adult rules
- Enjoys talking with friends
- Conversations are often about social matters
- May complain that others do not understand
- Usually does not like grammar
- Likes to argue rather than discuss
- May use loud voice

Socioemotional

- 2nd separation-individuation task—begins to form identity and prepare for adulthood; increased conflict with parents, although still places strong value on family; increased interest in peers and anxiety about peer acceptance
- Girls may form identity and prepare for adulthood through establishing relationships and emotional bonds
- Pressure to conform with peers
- Heightened interest in how body image affects feelings about body, thought processes, and social interactions
- Same sex relationships still most common; experimentation with dating
- May be demanding and defensive; mood swings common
- Egocentric
- Can be sensitive and worried about body features, personality, being embarrassed or left out, grades, tests, or how things will turn out
- Transition to junior high stressful (no longer top dog)

Socioemotional (cont.)

- Many ethnic minority youths have multiple disadvantages:
 - ♦ Prejudice, discrimination, and bias because of their ethnic minority status

- ♦ Stressful effects of poverty
- ♦ Poverty, not ethnicity, explains some problems ethnic minority youths face
- Even economic advantages of class can't protect one from prejudice and discrimination
- Recognizes that differences exist between and within groups

Moral

- Wants to be a “nice” person and live up to the expectations of people one knows and cares about; adopts parents’ moral standards on important issues; reason to be good is so others will think well of one (social approval) and one can think well of self
- Continues to learn culture-based moral values, though there may be conflict if these differ from the dominant society’s values

Indicators of Concern (Early Adolescence)

- By end of period, physically immature, small, not showing signs of puberty or secondary sex characteristics (wide range here; girls mature earlier)
- Poor motor skills, coordination
- Lack of peer group relationships and identification with peers
- Can't think hypothetically; doesn't consider consequences of actions
- Can't put him/herself in place of another; doesn't consider how behavior affects others
- Difficulty problem solving; doesn't work through systematically and weigh solutions
- Poor school performance
- Doesn't reject or question parental standards and express self through clothes, hair, and other lifestyle choices
- Moral behavior still dependent on presence of external authority to enforce rules (not internalized)
- Poor self-esteem
- Emotional and behavioral problems (anxiety, depression, withdrawal, aggression, lack of impulse control, anti-social behavior)
- Withdrawal from friends and from activities once enjoyed
- Changes in eating and sleeping habits
- Indecision, lack of concentration, or forgetfulness
- Abuse of alcohol or drugs

Adolescence (15 to 19)

Physical

- Preoccupation with body image (continues throughout adolescence)
- Late-maturing girls (by 10th grade) are more satisfied with their body image than early maturing girls

Cognitive

- Attends tenth through twelfth grades
- Continuing formal operational thought with abstract, idealistic, logical, hypothetical-deductive reasoning, complex problem solving, and critical thinking
- May think in black and white and tolerate gray
- May enjoy debating and arguing
- Has a strong sense of awareness
- May be judgmental of adults or peers if they do not do what is “fair”

Language

- May not like to communicate with adults
- May question adult authority and adult rules, although less overt testing
- Enjoys talking with friends
- Conversations are often about social matters
- May complain that others do not understand
- Usually does not like grammar
- Often argues rather than discusses
- By end of this period, vocabulary and grammatical advantage for girls disappears



Socioemotional

- Building identity (separation-individuation task) continues; may be even more profound in middle and late adolescence than earlier; internal self, social self, and self-esteem are prominent
- Parental-youth interactions influence autonomy (e.g., relative strictness or permissiveness)
- Girls may form identity and prepare for adulthood through establishing relationships and emotional bonds
- Gendered dating scripts may guide interactions: males – proactive, interested in girls’ physical qualities, and may initiate relationship; females – reactive to males, interested in interpersonal qualities; group dates are common
- Interest in forming romantic relationships part of separation task; implies separation from family
- Identity involves gender role stereotyping; some minority cultures have larger gender difference in status than mainstream culture
- Concerned about own thoughts, opinions, and ideas
- May be more giving in relationships, more appreciative of family, more friendly and outgoing; better able to control and express feelings and accept criticism
- Cultural differences may cause conflict (e.g., Latino and Asian dating standards may be more conservative than those of the mainstream white and/or African-American cultures)

Moral

- Wants to be a “nice” person and live up to the expectations of people one knows and cares about; may adopt parents’ morals on important issues
- “Personal choice” seen as justification for opposition to parental and societal standard
- Reason to be “good” is so others will think well of one (social approval) and one can think well of self (self-esteem)
- Physical, psychological, and culturally defined gender differences may influence masculine and feminine moral behavior (e.g., “justice” masculine perspectives vs. “care” feminine perspectives,) though many adolescents will have qualities of both
- Minority cultural perspectives may differ from those of the dominant culture—may be based more on familial and communal expectations; differences may cause moral dilemmas

Indicators of Concern (Adolescence)

- Physically immature, small, not showing signs of puberty or secondary sex characteristics (wide range here; girls mature earlier)
- Poor motor skills, coordination
- Has not developed one-on-one friendships with same and opposite sex peers
- Can't think hypothetically; doesn't consider consequences of actions; difficulty problem solving
- Poor school performance/excessive absences
- Can't put him/herself in place of another; doesn't consider how behavior affects others
- Moral behavior still dependent on presence of external authority to enforce rules (not internalized)
- Sense of self still dependent on family or peer group (not individualized)
- Poor self-esteem/guilt
- Emotional and behavioral problems (anxiety, depression, aggression, lack of impulse control, anti-social behavior)
- Withdrawal from friends and from activities once enjoyed
- Changes in eating and sleeping habits
- Indecision, lack of concentration, or forgetfulness
- Abuse of alcohol or drugs
- By the end of this period, failure to plan for the future; sets very unrealistic or grandiose goals

Normal Developmental Challenges and Strategies

Not surprising to anyone who has been around children is the fact that caring for them can be both enjoyable and challenging. Challenging phases of development may be normal for children, but may pose significant tests of patience for parents or caregivers. For families who already face numerous social, environmental, and/or psychological stresses (e.g., loss of a job, death in the family,) encountering the challenges associated with normal child development may be enough to overwhelm parents or caregivers, and may possibly contribute to the occurrence of child abuse or neglect.

SOME NORMAL CHALLENGES ARE:

- **Colic** – Typically observed from 0 to 3 months of age, this includes fussy, intractable crying (20 minutes to two hours at a time,) one or more times per day, in absence of hunger or physical symptoms. Caring for a baby who has colic can lead to frustration at not being able to pacify the baby. It may also lead to a feeling of insecurity about one's ability to parent effectively. If colic becomes a chronic problem, it can jeopardize the formation of a healthy caregiver-infant attachment.
- **Night crying/awakening** – Typically observed at 4+ months of age, this continues after the infant has given up middle-of-the-night feedings. This can also occur following an acute illness that has involved nighttime contact with parents or caregivers. If night crying/awakening becomes an ongoing experience, parents or caregivers can become sleep deprived, leading to frustration and low energy for carrying out daily household, employment, and care giving responsibilities.
- **Separation anxiety** – Typically observed from 6 months to 2½ years of age, this includes crying, clinging, and fearfulness when the parent or caregiver is not present. From 6 to 12 months of age, this anxiety can occur when the parent or caregiver is out of the infant's visual field. Parents or caregivers with multiple tasks to complete in a given day may become frustrated by the child's need to be close. They may also perceive the child as spoiled and punish harshly to "train" the child.
- **Exploratory behavior** – Typically observed from 9 months to 2½ years of age, the child "gets into everything" repeatedly, out of normal, healthy curiosity. This interest in the environment can be physically dangerous for the child, provocative to parents or caregivers when valued possessions are touched (e.g., TV or DVD,) and embarrassing when displayed in front of others, who may not understand and become impatient with the normalcy of exploratory behavior.
- **Negativism/tantrums** – Typically observed from 1 to 3½ years of age, a child delights in refusing most adult requests or suggestions, often becoming generally argumentative. The child's "no" is a healthy sign of developing self-identity and independence, but can tax parent or caregiver tolerance.
- **Poor appetite** – Typically observed from 1½ to 3 years of age, poor appetite is normal because the child's growth rate has slowed. Poor appetite can often lead to battles at the dinner table and conflict among the parents or caregivers. Concern about the child's nutrition, or frustration at a failed attempt to teach the child to follow directions, may lead parents or caregivers to force-feed or engage in power struggles—things which often make matters worse.
- **Toilet training** – Typically observed from 1½ to 5 years of age, this is the process by which a child learns to be independent in using the toilet. Readiness for daytime training usually occurs by 24 months of age, since sphincter control is typically achieved between 18 to 24 months. Nighttime

bladder control may not be achieved for several years. Pressure around toilet training can occur when parents or caregivers feel the need to toilet train early (e.g., due to requirements of child care settings that children be toilet trained; due to money constraints that could be helped by “getting out of diapers.”) Pressure can also build when parents or caregivers incorrectly conclude (due to a lack of knowledge about child development) that their child is developmentally behind or just being resistant. It is also common for boys to be fully trained later than girls.

- **Lack of compliance with parental or caregiver expectations** – Typically observed from 6 to 11 years of age, this often occurs due to self-assertion, control conflicts, or simple lack of attention or forgetfulness. This is a natural part of a child’s development and is important for the formation of independence. Parents or caregivers trying to keep their child safe or teach respect for authority may see noncompliance as a lack of discipline and respect, possibly leading them to “turn up the heat” as they discipline. The reverse may also occur—parents or caregivers may conclude that their child is capable of self-care, possibly leading them to provide inadequate supervision and care giving. Cultural ethnic groups and other groups that value interdependence above independence may show variations in their approaches to training of children at this stage (e.g., military families, American Indian families, African-American families.) For such children, “belonging” would be the essence of “identity,” and thus would be the healthy resolution of this stage of development (Joe, 1989.)
- **Attempts at independence, vacillations in mood, lack of responsibility and compliance, and experimentation with behaviors that anger or frighten adults** – Typically observed from 12 to 18 years of age, the youth’s capacity for self-care, coupled with the desire to make his or her own decisions and a tendency to avoid responsibility, may lead to lack of supervision on the parent’s or caregiver’s part or an inability to control youth behaviors that are particularly problematic. Any of these behaviors may lead to confrontations with parents or caregivers that result in physical or emotional abuse. This can be a particular issue for recent immigrants (e.g., immigrants from Latin America, Hmong) or American Indian families that have recently migrated to urban areas for the first time. As youth become more acculturated to mainstream expectations for adolescents to be increasingly autonomous and even rebellious, parents from indigenous populations may interpret such behavior as highly disrespectful and struggle to regain a sense of parental authority.

HOW THE CASEWORKER CAN HELP:

- Discuss with parents or caregivers what to expect and that developmental phases are considered normal. If they are able to accept this, they will not take their child’s behavior personally; assume that the child is trying to anger them; or that the behavior is a result of the parental or caregiver failure. Several good internet sites are available that have materials for parents dealing with developmental stages: Zero to Three (www.zerotothree.org) and the National Network for Child Care (www.nncc.org.) More information about resources is included in the “Suggested Resources” section at the end of this book.
- Offer specific information or connect families with resources that can educate them about child development, parenting challenges, and positive parental responses. In addition to this Resource Book, you can obtain information on child development from places such as pediatricians’ offices, local hospitals, and early childhood education clinics. Also look for community resources that specialize in providing culturally responsive family services.

- Use the family's natural support system as a way to help parents or caregivers deal with challenging developmental behaviors. In many cultural groups, including African-American, American Indian, and Hispanic populations, the extended family may be very involved in the ongoing care giving of children.
- Assist the family in identifying and implementing specific alternatives to violence within the home, including steps for coping when frustration builds (e.g., calling someone when they need a break; seeking reassurance and help from a friend, mentor, or professional; setting up a reward for the parent at the end of the day—a hot bath, a good book.)
- Get feedback from the parents or caregivers and older children on how their plans for non-violent responses and coping are working.

PARENT/CAREGIVER ACTIVITIES TO PROMOTE HEALTHY GROWTH:

Birth to 4 Months

- Offer me a finger to hold. Listen to me and learn my responses. Smile and touch me when you talk to me. Tell me I am wonderful.
- Develop trust. Gently hold me while talking in sweet encouraging tones. Call me by name and make eye contact.
- Pick me up when I cry and reassure me. Don't leave me alone crying and give me the impression that no one cares for me.
- Learn how to soothe me and meet my needs before I cry.
- Gently rub my back, sing to me, play music for me, or bounce me gently to music. I am sensitive to sound, so keep music low.
- Hold me securely in new places and protect me.
- Keep me clean, well fed, and clothed appropriately for temperature.
- Give me colorful toys that make interesting sounds.
- Sucking calms me, so let me suck my fingers or a pacifier. Be gentle and don't interrupt my sucking by pulling or jiggling something I'm sucking on.

4 to 6 Months

- During bath time, try washing me in a sitting position; help me sit up for 5-10 minutes. I may also want to sit up and play. Help me keep my back straight while I sit for 5-10 minutes.
- Give me safe healthy finger foods at 5-6 months (e.g., crackers.)
- Lay me on a blanket on the floor and let me roll and reach.
- Spend time with me (toy play, smile, nod, talk, and laugh.)
- Give me toys or attention when I need a distraction.
- Respond to my fears and cries by holding, talking to, and reassuring me. Tell me what I'm feeling and that it's okay.
- Talk to me, sing to me, or give me my favorite toy at diaper changing time. Don't scold, make loud noises, or frowning faces.
- Keep me in the back seat in my car seat, even if I complain. Distract me with some toys and reassure me. Put my seat where I can see outside.
- Avoid separating me from you for days. I need consistent, reliable relationships, so if you leave me for long periods, expect me to be more clingy for a while and to need more reassurance.

6 to 12 Months

- Play peek-a-boo, puppets, wave bye-bye; teach me words and colors, even if I can't repeat the words right now.
- Have a regular bedtime routine. Slow my activity an hour before bedtime; rock me, pat my back, and bring my favorite blanket. Once dry, fed, and well prepared for bed, leave me with a kiss. Ignore my cries for a few minutes until I am asleep.
- Encourage physical exploration within your eyesight.
- Keep dangerous objects away from me and baby-proof my environment. Be there to comfort me when I get hurt.
- Help me stand by holding my hands. Make sure my heels are flat.
- I may purposefully drop and throw things as an experiment. Give me safe things to drop and throw.
- Open a cupboard in the kitchen kept safe for my exploration. Keep only non-breakable objects that are baby-friendly.
- Give me something interesting on my tray to explore at mealtime (e.g., cooked spaghetti, spoons.)
- Do not force me to eat, and understand that I am learning and will be messy with my food.

12 to 24 Months

- Learning to walk takes time. Hold my hand and encourage me to take steps when I'm ready—don't rush me.
- If I grab, hit, or bite when I'm mad, don't scold me or hit me. Teach me words to use instead of hurting others.
- It will take time before I'm able to do many things. Set limits, but I will break rules many times before I learn. "No!" is not enough; please explain why (e.g., "The stove is too HOT!") Move me and show me a safe place to play.)
- Give me choices whenever possible. Don't say "no" too often, and distract me if I am refusing something. Reward me for good behavior. Ignore my "no" if I do not get a choice.
- Let me scribble with thick washable crayons or felt markers; tape a paper to the table so it doesn't slip.
- Compare colors and sizes with me (big spoon, red balloon.)
- Read to me. Tell me about the story; let me pat the pages and make noises; help me learn to turn pages by half lifting one.
- Building blocks, sandboxes, ride and pull toys, jack-in-the-boxes, music toys, and balls are very important learning tools.
- Understand that "me" and "mine" are important before I can learn about "you" and "yours." Set up a box that is mine.
- Teach me about not hurting others and about sharing, but don't shame me. Be patient, and encourage my empathy for others.

24 to 36 Months

- Let me do it myself when possible. Let me feed myself, even if I'm messy. Give me two choices when you can.
- Let me make choices about the food I eat, and let me refuse food. Reduce in-between snacks so I will be hungry at mealtimes. Don't use food as a reward or punishment.
- Teach me about dangerous things (matches, knives, strangers, stray animals, cars, etc.) Significant consequences should be given for dangerous behavior after giving warnings.
- Naps are still important to reduce cranky and moody behavior.
- Give me a warning that it will soon be time to move along.
- Don't hurry me too much; I need patience and time to learn.
- Read to me, color with me, and teach me games.
- If there is a new baby, remember I will be jealous. Assure me of your love, give me special time, and let me help with the baby.
- Tell me what I'm feeling, comfort me, and don't scold me.
- Offer a hand when I'm in a new situation. (This substitutes for picking me up.) Don't insist I have to grow up.
- Blow bubbles for me. Teach me to catch and throw a ball.
- Respect my fears and don't force me into fearful situations. Comfort me and encourage me that there is nothing to fear.

Potty Training Tips

- No age is exact for toilet training. Watch for me to grimace at dirty diapers, show you my wet pants, and stay dry for up to two hours. I need to be verbal enough to understand toilet training.
- Change me as soon as possible; tell me it's nice to be clean.
- Let me have a toy to keep me happy and busy on the potty-chair. Put me on the potty briefly at first (up to 5 minutes.)
- Praise my efforts and encourage me to let you know when I need to go potty. Teach me the family words for toilet training.
- Dress me in easy to remove clothing; be patient, never scold me; visit the potty before going somewhere; help me wipe, teach me to wash my hands, and show me how to flush.

Tantrums

- Make sure I get enough sleep, eat healthy, and keep a regular routine. I need physical activity during the day. Teach me to ride a tricycle; encourage running, dancing, and jumping.
- Learn warning signs and distract me. Don't expect too much.
- Since tantrums are a release of frustrated feelings and a way to get attention, ignore me if I'm in a safe place. Don't reward tantrums. Stay calm and leave me, reassuring me you will be back when I'm quiet. When I stop, talk to me; tell me what I'm feeling. Help me express my frustration in words.

3 to 5 Years

- Discuss physical gender differences with me. Teach me the proper names for body parts without shame. If I am old enough to ask the question, I am old enough to understand the answer. Don't give me more information than I ask for.
- Create a home library with interesting books about heroines and heroes, fables, and fun stories. Read to me every day, and let me point to pictures, fill in missing words, predict what happens next, and discuss the ideas in the book. Understand when I want my favorites over and over again.
- Remember, rewards works better than punishment. Have a sticker chart, give balloons, pennies for the bank, etc.
- Play children's music; sing, clap, and dance with me.
- Encourage physical involvement and imaginative expression (e.g., "Itsy-Bitsy Spider" and "I'm a Little Teapot.")
- Teach me to count, sing my ABCs, and write my name with lots of patience. This will take time and repetition.
- I need a bike or trike, balls, clay, and play space with toys.
- Plant a garden or a pot from seed. Help me water it and watch it grow. Pick flowers for my table and let me eat the vegetables.
- Follow a routine at bedtime. Show me the clock and tell me it's time for bed. Let me pick out my bath toys, choose my pajamas, read me a story, etc.
- Spend time with me. Sing me a song; rub my back. Kiss me, say goodnight, I love you.
- Give me permission to say "no" to adults that make me feel uncomfortable. Talk with me and get to know how I'm feeling.

5 to 8 Years

- Discuss physical gender differences with me. If I am old enough to ask the question, I am old enough to understand the answer. Don't give me more information than I ask for.
- Create a home library with interesting books about heroines and heroes, fables, and fun stories. Read to me every day, and let me read a part of each book; discuss the ideas in the book.
- Remember, rewards works better than punishment. Have a sticker chart, give balloons, pennies for the bank, etc.
- Play board games with me.
- Sing, draw, and cook with me.
- Teach me new things with lots of patience. This will take time and repetition.
- I need a bike or trike, balls, clay, and play space with toys.
- Plant a garden or a pot from seed. Help me water it and watch it grow. Pick flowers for my table and let me eat the vegetables.
- Let me help with chores around the house.

Strategies for Play Groups

- Give flashlights to me and my friends. Let me turn out the lights. Teach us to make shadow puppets on the walls.
- Set up a folding table or chairs in the living room. Drape a sheet over it and let us play in the "tent" or "cave."
- Allow us to dig a hole in the back yard. Fill it with water.
- Remember attention spans and likes vary with children. Plan a variety of activities; be flexible. Allow for some children to move on while other children finish the activity.
- Encourage cleaning up when a child becomes bored with one activity before moving to the next activity.
- Organize a game of "Duck, Duck, Goose."
- Set up a tea party with juice and crackers with a toy tea set or plastic cups and plates. Tea parties can be taken outside.
- Give my friends and me the broom and mop for horse riding in the house on a rainy day.
- Set up a folding table on its side to create a stage for a puppet show.
- Dress up and act out children's stories.
- Draw faces on the tips of fingers and play finger puppets with friends. (Draw mouth in the crease of the finger.)
- Make a house out of a discarded appliance box. Cut a door and windows for my friends and me. Help us decorate.

8 to 12 Years

- Allow lights on after bedtime if I'm reading a book. Check out a new library book each time a book is read. Used bookstores are also economical resources. Let me choose.
- Turn off the TV and play a game with me or talk things over. Don't let me watch PG-13 or R rated movies.
- Bake cookies with me; we can wear aprons, and don't get too upset about how messy the kitchen becomes.
- Provide an allowance contingent on performing household chores. Encourage saving money in a piggy bank, and give me bonuses for a good attitude and/or an exceptional job done.
- Teach me cards and board games I can play with my friends.
- Encourage outside play (e.g., jump rope, skates, balls, etc.) Draw a hopscotch grid on the sidewalk with chalk.
- Teach me about nurturing by giving me responsibility for a family pet. Understand I may forget and remind me.
- I need to know how to swim to stay safe in water.
- Teach me about nature through camping, hiking, and going to the zoo.
- Let me organize a water fight with the hose and balloons.
- Establish family traditions. Remind me about what we did last year. Tell me why it is important.

Strategies for Child Safety

- Know where I am at all times. Teach me to check in and give me timelines. Provide clear instructions to me about what you believe is safe, and supervise my activities.
- Make my house safe, friendly, and child centered. Children can visit under your watchful eye.
- Get to know the parents in my neighborhood and my friends' parents. Teach me to keep away from places that are unsafe.
- Give me permission to say, "My mom or dad wants me home," or "My mom won't let me," if I need to make an excuse to get out of an uncomfortable or pressure situation.
- Teach me about drugs, alcohol, smoking, and teen pregnancy. Let me tell you how I feel about these things.
- Teach me how to value myself and care for myself. Value me.
- Teach me to be cautious of overly friendly adults or strangers.
- Ask me how I'm feeling. Listen. Keep communication open.
- Be reliable and predictable, and create a safe place for me to put my trust. Forgive me when I fail, and apologize when you have let me down. Teach me about respect by modeling it.
- Teach me about my bright future and celebrate each accomplishment along the way. Give me vision.

12 to 18 Years

- Be clear about what you expect of me. Set curfews and know where I am at all times. Make sure I check-in frequently.
- Start with small freedoms, assuring me that larger freedoms will be allowed once I've proven myself capable of the smaller ones.
- Allow me to have privacy by giving me a lock on my door, a journal, and by knocking before entering my room. My lock is a privilege, as long as I open the door when you knock.
- Allow me to have my own music in my room.
- Encourage me to express my feelings in writing and verbally. It's okay to be angry, but not mean.
- When I speak, listen to the feeling underneath, along with the words. Am I scared? Or hurting?
- Peers are very important for me. Allow me to talk on the phone and have friends over. Let me organize a slumber party, pool party, or homework session. Allow me and my friends to take over the living room for an evening.
- Let me wear what I like as part of self-expression. Go shopping with me to buy clothes we both like.
- Encourage volunteer or paid work. I need to build a resume. Instill responsibility and polite public behaviors.
- Support and encourage me to gain a special talent early in my teen years (dance, music, drama, sports, art, etc.)

Strategies for Dealing with Conflict

- Understand my need for developing a separate self, and do not take my struggles to gain independence personally.
- Understand that I still need supervision, guidance, and protection, even if I push you away or am critical of you. Troubled children often report a parent doesn't "love them enough" to wonder where they are or what they do.
- Acknowledge my feelings and maintain consistent consequences for my disobedience of clear limits you set.
- Consequences should always be related to my disobedience (e.g., if an hour late, set the next curfew time an hour earlier.)
- When I make mistakes, disobey, or lose my temper when you set limits, know that this is normal. Don't give up. Reassure me that you still care and won't give up on me.
- Give me another chance. I want your love and approval and will keep trying. Reassure me that you are still proud of me.
- Give me a vision for who I can become. Give me a reason why I should make healthy positive choices.
- Maintain communication and physical affection.

Challenges Beyond Normal Development



Prenatal Risks

The prenatal period sets the stage for the rest of a child's development throughout life. Though this will seem obvious to professionals, it may not be so obvious to some parents they work with. Helping expectant parents understand this and take care of themselves and their developing babies is one of the best ways we can prevent child maltreatment. The developing fetus is in need of nutrition, care, and protection from harm from the time the egg is fertilized. Several things increase the chances that a baby will be healthy. These include:

- Safe exercise
- Good nutrition
- Consistent doctor's care throughout the pregnancy
- Social supports for the parent(s)

TERATOGENS

Teratogens, or things that are harmful to the developing child, include:

- Cigarettes
- Alcohol
- Illegal drugs
- Some prescription drugs
- Radiation
- Environmental pollutants
- Disease (Rubella, HIV/AIDS, other viral diseases, and bacterial and parasitic diseases such as toxoplasmosis)

Teratogens seem likely to do the most harm during the embryonic phase, from fertilization to 12 weeks, when the parts of the body are forming. But because their effects are complex, it is better for pregnant women to avoid them throughout pregnancy.

OTHER HARMFUL FACTORS

- Malnutrition
- Lack of medical care (because of poverty or isolation or for any other reason)
- Rh-negative blood
- Chromosomal abnormalities
- Emotional stress
- Domestic violence
- Lack of social support
- Mother's lack of information about her needs during pregnancy

Failure to Thrive¹

“Failure to thrive (FTT) is a nonspecific term applied to infants and young children who are failing to grow in a normal fashion.” (Smith, 1997.) Most often, failure to thrive involves children under age 3. A diagnosis of failure to thrive is not based on a single measurement of a child’s weight and height, but is based on a pattern or trend of growth that is consistently less than expected for a particular child. Concern about failure to thrive arises when there is:

- Less than expected growth; and
- The child’s weight falls below the 5th percentile for his or her age, height is under the 5th percentile for his or her age, and/or weight and height are under the 10th percentile for his or her age; and
- There is a poor growth trend such that the child’s growth descends across two lines on a standard growth chart.²

Malnutrition, before and during the first few years after birth, has been linked to stunted brain growth and cognitive, social, and behavioral deficits.³ **Infants can be in significant, even life-threatening, danger if their nutritional needs are not met.** Potential failure to thrive in infants must therefore be assessed promptly, including a medical examination.

Failure to thrive can be organic; that is, it can be caused by an underlying physical disease. It can also be nonorganic; that is, the cause can be psychosocial and not the result of an underlying medical condition. The cause of failure to thrive can also be mixed; that is, it can be caused both by an underlying disease and by a problem in parent-child interaction or in the home environment (Smith, 1997.) There should be both a social evaluation (including evaluation in the home environment) and a medical evaluation and diagnosis prior to the conclusion that nonorganic failure to thrive is occurring.

Many factors affect growth and should be considered before a child is labeled failure to thrive. For example, the child may be normally thin or short. Some children are normally in the 5th percentile for height and weight and continue on a normal growth pattern in that percentile. Children who were born prematurely will normally be somewhat smaller than others of the same age during the first year of life. The mother may also have medical issues that can interfere with lactation and, therefore, with providing sufficient nutrition for the child. Certain medical conditions (e.g., Down’s syndrome) can also affect growth (Dubowitz and Black, 1998.)

Even when failure to thrive is diagnosed, it is important to realize that although it may reflect inadequate nutrition or a problem in the parent-child relationship, it may not. If failure to thrive is identified as nonorganic (psychosocial) in origin, it should be because there has been a problem identified in the home environment, not solely because of the apparent absence of a medical cause (Dubowitz and Black, 1998.)

The crux of failure to thrive is caloric intake. “Either the calories are not being offered to the child, the child is not taking the offered calories, the child is using calories at an increased rate, or the calories are not being absorbed into the body from the gastrointestinal system.” (Smith, 1997.) To clarify the pattern

¹ Excerpted and adapted with permission from Feild, T. & Winterfeld, A. (2003). *Tough problems, tough choices: Guidelines for needs-based service planning in child welfare*. Englewood, CO: American Humane and Casey Outcomes and Decision-Making Project.

² Clinical growth charts can be found in the “Tables & Charts” section of this Resource Book.

³ Politt and Gorman, 1994; Shonkoff and Phillips, 2000; and Karr-Morse and Wiley, 1997, cited in U.S. Department of Health and Human Services, Administration for Children and Families, Children’s Bureau, 2001.

for each child, a comprehensive medical evaluation should occur and psychological evaluations may be needed.

To supplement the medical evaluation, four main areas should be assessed by social workers to clarify the reasons for nonorganic or mixed failure to thrive (Dubowitz and Black, 1998):

- Child factors;
- Parental factors;
- Family factors; and
- Community and cultural factors.

A child's feeding history should always be assessed, as well as whether there is adequate food in the home. Workers will need to ask what the child is fed, when (how often,) where the child is fed, who feeds the child, and who eats with the child. Observe a feeding in the home, if possible. For infants, assess the positioning of the infant (i.e., how the child is held and whether it is a comfortable position for feeding,) general interaction between parent and child, and feeding interaction (e.g., does the parent make eye contact with infant while feeding.) Observe whether the child appears to have motor issues that interfere with feeding, the child's behavior during feedings and the parent's response, and whether the child is capable of feeding himself.

Responding to failure to thrive often requires a comprehensive, multidisciplinary team approach. Often Children and Youth Services (CYS) comes into a case after a medical diagnosis of failure to thrive, and the social worker's job is to address psychosocial factors and ensure that medical recommendations are followed. Alternatively, the CYC worker may see a child as part of an assessment following a referral to CYC and, thus, may need to arrange for medical attention. Tailor your approach to a family's strengths and needs, and be sure that there is adequate medical follow-up to monitor the child's health—especially for infants—for whom feeding issues can quickly become a life-threatening emergency.

Children with Disabilities

The federal government defines the term “child with a disability” as a child “with mental retardation, hearing impairments (including deafness,) speech or language impairments, visual impairments (including blindness,) serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning disabilities” who needs special education and related services (House Bill 1350, the Improving Education Results for Children with Disabilities Act of 2003.)

“A developmental disability is a disability that is observed before the person reaches 22 years of age, which constitutes a substantial disability to the affected individual, and is attributed to mental retardation or related conditions (including cerebral palsy, epilepsy, autism, or other neurological conditions,) when such conditions result in impairment of general intellectual functioning or adaptive behavior, similar to that of a person with mental retardation” (Developmental Disabilities Resource Center, n.d.) The disabilities may be biological or the result of an accident (e.g., head trauma, lack of oxygen for an extended period.)

Children, ages 3 to 9, may also be eligible for special educational and related services if they show developmental delays in one or more areas. “Developmental delay” is defined as slowed or impaired development in a child under 5 that may or may not be associated with congenital or biological risk factors (e.g., metabolic disorders, chromosomal conditions associated with mental retardation, low birth weight, or other medical conditions.) A child less than 3 years of age, who lives with one or both parents or caregivers who have a developmental disability and do not receive supportive services, may also be considered.

Children with disabilities show significant difficulties in one or more of the following areas: cognition, speech and language, motor skills, vision, hearing, emotions and behavior, and self-help skills. Accurate diagnosis, careful assessment, and appropriate medical management are important in helping parents, caregivers, educators, and health personnel to work together effectively on behalf of a child with a disability.

Children with disabilities, particularly children with multiple disabilities, are at greater risk for child maltreatment than children without disabilities (Sullivan & Knutson, 2000.) The reasons children with disabilities are at greater risk for child maltreatment, compared to children without disabilities, seem to center around two areas:

- Parent or caregiver psychological feelings and adjustment to having a child with a disability (e.g., grief over the loss of a “dream child”); and
- Challenges associated with providing care for a child with disabilities (e.g., stress associated with special diets, medical treatments, additional laundry, therapy appointments, social restriction and isolation, financial pressures, anxiety about the future, and ongoing loss of sleep.)

However, risk to these children can be reduced if appropriate assessments and services are provided. For example:

- Opportunities to talk openly with nonjudgmental peers and professionals;
- Participation in day programs or summer camps for children and youth with disabilities;
- Provision of respite care as needed; and
- Assistance with financial demands associated with the disabilities.

Although there are several types of disabilities that affect children (e.g., mental retardation, visual or hearing impairment, cerebral palsy, language problems,) two disabilities often observed in maltreated children are Attention Deficit Disorder and learning disabilities.

Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) – These are thought to be neurochemical disorders that interfere with attention. ADD is a condition characterized by inattention and impulsivity. If children show these symptoms along with hyperactivity, they are considered to have ADHD. Most children identified as having ADD are also hyperactive and restless (ADHD,) have poor impulse control, and are prone to outbursts of anger and aggression. Often they are emotionally labile and immature, and are resistant to discipline. Unless otherwise noted, the information presented in this section was obtained from the National Alliance for the Mentally Ill (2001) and Children's Disabilities and Special Needs (2001.)

Approximately 3% to 10% of all school-aged children in the U.S. (over one million) have ADD or ADHD (Children's Disabilities and Special Needs, 2001,) making it the most commonly diagnosed behavior disorder in young persons. Boys are about three times more likely than girls to have ADHD. ADD, characterized by predominantly inattentive behavior, is found most often in adolescent girls (National Alliance for the Mentally Ill, 2003.)

Causes of ADD and ADHD do not include dysfunctional parenting, lack of intelligence, or poor discipline. ADD and ADHD are thought to be biologically-based disorders. Compared to individuals without these disorders, those with them show lower levels of the neurotransmitter dopamine in critical regions of the brain and lower metabolic activity occurring in regions of the brain that control attention, social judgment, and movement. ADD and ADHD also seem to have a genetic component, running in families. Other causes of these symptoms include central nervous system diseases, prenatal drug exposure, and serious emotional disturbances. ADD and ADHD are rarely caused by diet. However, there is evidence that diet may positively or negatively affect the management of these disorders.

The information presented in this section was obtained from the American Academy of Child and Adolescent Psychiatry (1997.)

Learning disability is broadly defined as a neurological disorder in which there is a significant discrepancy between children's achievement (in reading, spelling, written language, mathematics, and/or language skills) and their ability. The discrepancy is not the result of lack of educational opportunity, emotional disturbance, physical disability, or health impairment. These children have difficulty with information processing because of perceptual, memory, attention, and language defects.

Learning disabilities are thought to be caused by a difficulty with the nervous system that affects receiving, processing, or communicating information. These disabilities may also run in families. Some children with learning disabilities are also hyperactive, unable to sit still, easily distracted, and have a short attention span. Learning disabilities may also occur as a result of chromosome disorders (e.g., Fragile X, Turner's Syndrome,) traumatic brain injuries, or a history of recurrent ear infections.

Approximately 10% to 15% of school-aged children have a learning disability.

Alcohol and Drug Exposure

The most common trauma to a fetus that potentially leads to harmful long-term developmental problems is exposure to alcohol and illicit drugs, defined by more and more professionals as a form of maltreatment. When women use alcohol and illicit drugs during pregnancy, the substances pass through the human placenta and can affect the developing fetus (Ornoy, 2002.) Fetuses that are exposed to alcohol and illicit drugs can have major organ malformation, growth retardation (Stratton et al., 1996, as cited in Autti-Ramo, 2000,) and facial and congenital anomalies. Fetuses are also at increased risk for being stillborn (Ornoy, 2002.)

Infants exposed to alcohol or illicit drugs before birth are called “drug-affected babies.” The effects of alcohol on fetuses are described as “Fetal Alcohol Syndrome” (FAS) for more recognizable and severe effects and “Fetal Alcohol Effects” for more subtle indicators.

Fetal exposure to alcohol and illicit drugs can result in damaging effects across all developmental domains. For example, in the physical domain, alcohol and drug-exposed fetuses have physical effects such as facial anomalies (e.g., eyes droopy or far apart, thin upper lips, asymmetrical ears,) small heads, small body size/weight, poor weight gain, and failure to grow. Fetuses exposed to crack-cocaine and other illicit drugs often experience varying levels of withdrawal symptoms at birth, and may exhibit physical and behavioral problems similar to those seen in FAS babies.

The developmental effects to the fetus depend on the type of substance, dose, duration of exposure, and the age of the fetus. For example, the fetal developmental stage is related to the effects observed (i.e., drinking in the first trimester is associated with physical malformations, whereas drinking in the second trimester is associated with impaired infant growth.)

Children with fetal alcohol exposure often display uneven development in various domains. For example, an adolescent with FAE may do well in school, but show dramatic immaturity and impulsiveness in social relationships.

Many identifiable drug-affected babies are at risk of abuse and neglect because the alcohol/drug involvement of the parents or caregivers makes it difficult to care for the babies while under the influence. There are few alcohol/drug in-patient treatment programs that serve pregnant women, and fewer still that serve mothers and their children.

Effects of Maltreatment on Development

Children who have been maltreated often display a variety of problems that may benefit from special services. All concerns about special needs should be evaluated and appropriately addressed. As a worker, you will want to look out for potential developmental problems in maltreated children, so that you may better address their safety and well-being through appropriate service provision. Some developmental and behavioral problems commonly observed in maltreated children are summarized in the table below.

Developmental Problems Observed in Maltreated Children⁴		
<i>Behavioral</i>	<i>Social-emotional</i>	<i>Cognitive</i>
<ul style="list-style-type: none"> • Aggression • Physical violence (to people, animals, objects) • Impulsiveness • Hyperactivity • Out-of-control behavior • Noncompliance • Negative verbal interactions • School discipline referrals and suspensions • Juvenile delinquency and criminal behavior • Conduct disorder • Self-destructive behavior <ul style="list-style-type: none"> ◆ Suicide ◆ Self-mutilation • Enuresis, Encopresis • Substance abuse • Psychosomatic symptoms • Sexual acting out • Perpetrator behavior with other children • Eating Disorders 	<ul style="list-style-type: none"> • Problems with peers <ul style="list-style-type: none"> ◆ Lower peer popularity ◆ Fewer prosocial interactions ◆ Greater negativity in interactions ◆ Less peer interaction • Poor attachment to caregiver • Deficits in empathy and social sensitivity • Unfriendliness • Withdrawal • Avoidance • Fearfulness • Anxiety • Negative emotions • Unhappiness • Low self-esteem • Sense of worthlessness • Hopelessness • Mental health disorders • Depression • Post-traumatic Stress Disorder • Low ego control 	<ul style="list-style-type: none"> • Low academic achievement • Poor problem solving • Poor reasoning skills • Poor listening comprehension • Easy distractibility • Low average to borderline levels of intellectual functioning • Impaired social and moral reasoning <ul style="list-style-type: none"> ◆ External locus of control orientation ◆ Poor understanding of social roles • Poor receptive and expressive language • Less creativity

EFFECTS OF MALTREATMENT ON ATTACHMENT

Many abused and neglected children experience some degree of insecure attachment (see pages 6-7 in this book.) Frequently, their parents or caregivers have had trouble meeting their needs due to limited knowledge, excessive environmental stresses, or their own psychological challenges. Insecurely attached infants often become older children who have an unsteady and sometimes compromised foundation. Insecurely attached children are more likely to show:

⁴ Information in this table comes from the following sources: Angold, 1988; Cicchetti, 1987; Dubowitz, Harrington, Staff, Zuravin, & Sawyer, 1994; Eckenrode, Laird, & Doris, 1993; Famularo, Kinscherff, & Fenton, 1990; Haskett & Kistner, 1991; Hochstadt, Jaude, Zimo, & Schachter, 1987; Kiser, Heston, Millsap, & Pruitt, 1991; Koverola & Foy, 1993; Kurtz, Gaudin, Howing, Wodarski, 1993; Salzinger, Feldman, Hammer, & Rosario, 1993; Sawyer & Dubowitz, 1994; and Shonk & Cicchetti, 2001.

- Delays in any of the developmental domains;
- Unusual fears for their age in leaving the parent or caregiver—they are less likely to have developed an age-appropriate sense of autonomy;
- Unusual ease in appearing to attach to another adult, with no signs of missing the parent or caregiver;
- Aggression, withdrawal, or anxiety-based hyperactive behaviors;
- Conflictual or superficial relationships with peers and significant adults; and
- Impaired “social cognition” or awareness of oneself in relation to others and awareness of the feelings of others, resulting in lack of empathy.

Separation from a parent or caregiver, especially under stressful circumstances or for prolonged periods of time, negatively affects most children, regardless of their attachment level. Children may be frightened, withdrawn, or aggressive. However, children who are not securely attached to their caregivers are particularly vulnerable to separation.

How the caseworker can help:

You can do things to help preserve or prevent erosion of a possibly shaky attachment, should children need to be removed from their homes.

- **Remember that birth parents, as well as children, grieve** when their child enters care. Thoroughly explain and discuss the reasons for the removal and placement of the child with the parents. Use interactional listening skills to acknowledge the parents’ anger and grief in response to the loss of their children, and expect them to be initially resistant. The Child Welfare Professional should be supportive throughout the process.
- **Involve parents in all aspects of the planning and placement process.** Research has demonstrated that most parents are more resistant to working with the agency when their child has been “whisked away to the unknown” and they are isolated at home. Some places where a parent might be involved are:
 - ◆ Providing input to planning pre-placement (if possible);
 - ◆ Information gathering;
 - ◆ Identifying problems and problem-solving; and
 - ◆ Participating in medical appointments and school conferences.
- **Encourage parents to help explain the reasons for the placement to the child, and give the child a positive parting message.** This should help comfort the child and help reassure the child that they will work with the Child Welfare Professional, so the child can return home. The child may have concerns about loyalty. She needs a consistent message from all persons involved that she does not have to make a choice between her biological parents and her caregivers.
- **Ask parents to provide in-depth information** regarding the child’s schedule, routines, likes, dislikes, and needs to help the caregivers maintain continuity for the child. It is very helpful if the parent can communicate this information directly to the caregiver.
- **Schedule pre-placement visits to the new home** with the biological parents so the child can become familiar with the caregiver and environment.
 - ◆ Involve parents.
 - ◆ Provide child with familiar belongings to take with her, or allow her to select a favorite toy or doll as a transitional attachment object.
 - ◆ Do not use trash bags to pack a child’s belongings. If suitcases or boxes are not available, use grocery bags instead.

- ◆ Try to involve parents in helping the child pack, because this helps the child perceive that child has “permission” to go.
- **Arrange for as much family contact as possible and appropriate** (including in-person, phone, email, and letter contact.) In-person contact is critical, especially for infants and toddlers. Research has shown that children who have regular contact with parents have better outcomes in foster care than children who do not have such contact (e.g., less depression, less anxiety, better self-esteem, and increased likelihood of reunification.)
- **Ensure that the child and parent have family pictures.**
- **Place children with their kin (relatives, other family members, close friends) whenever possible.** Placement with kin allows children, on a daily basis, to maintain ties in environments that are more similar to their home, family, culture, and community.
- **Encourage substitute caregiver to talk daily with child about absent caregivers, using photographs if possible.**
- **Do not criticize parents or caregivers** as you discuss with children the family status and issues to be addressed, because:
 - ◆ When you attack the family, you attack the child. Remember that the child is a member of the family.
 - ◆ Despite a child’s own potential anger with parents or caregivers, the child will defend them. If you criticize the parents or caregivers, you may lose the relationship you have established with the child.
 - ◆ Do not assume that a child’s expressed anger at his or her parents is related to the severity of neglect or abuse. Anger is often seen in young children as a result of the grieving process related to separation from their families.

EFFECTS OF MALTREATMENT ON BRAIN DEVELOPMENT

The process of brain development, particularly in the early years, is constantly modified by environmental influences (Glaser, 2000.) Because child abuse and neglect function as an environmental influence, the occurrence of child maltreatment may affect how the brain develops—ultimately affecting the physical, cognitive and language, and psychosocial development of children.

Although there are multiple ways in which maltreatment may be linked to brain development, two ways in which maltreatment is thought to affect brain development involve the environmental stimulation received by the child and the amount of chronic stress the child might experience as a result of maltreatment.

- **Environmental stimulation** – During the first two years of life, there is a genetically determined overproduction of axons, dendrites, and synapses in different regions of the brain. (Synaptic connections allow brain signals to flow to appropriate areas.) However, not all synaptic connections survive. During this period, the determination of which synaptic connections will persist is regulated by the environment and dependent on the environmental information received by the brain. Neglect, and the limited environmental stimulation that is often associated with neglect, may lead to changes in brain development (the elimination of certain synaptic connections and the failure to develop other connections) that may result in permanent deficits in cognitive abilities (Glaser, 2000.)
- **Acute stress** – When children respond to stressful events, they experience a physiological coping response that involves the sympathetic nervous, neurotransmitter, and immune systems. The reactions and operations of these systems can alter the development of multiple neurotransmitter systems and promote structural and functional alterations in brain regions (Kaufman & Charney, 2001.)

A child who encounters one or more episodes of child maltreatment will experience these psychological responses that, over time, will have an effect on brain development.

Although research in this area has not conclusively determined a direct link between child maltreatment and brain development, studies are finding differences in brain structure between people who have been maltreated and those who have not. These studies show, among other things, differences in the size of various regions of the brain (De Bellis et al., 2002.) The differences in brain structure and chemical processes are also being linked to problems in the cognitive and psychosocial domains (e.g., a link between maltreatment and depression.) Unfortunately, because many of these studies involve people who also have mental health or other related issues, it is hard to know for sure if the maltreatment itself, or some other issue, has led to the differences noted.

Effects of Separation and Loss on Children

INFANCY (BIRTH TO 12 MONTHS)

- Babies entering care frequently have not had needs met, and may improve when placed in a more responsive environment. However, when infants who have developed attachments to their interim caregivers are moved back home, to another placement, or an adoptive home, they may be at risk, particularly if they do not receive sensitive and consistent care in the new home, or if moves are frequent. Frequent moves can lead to diminished trust and future socioemotional and cognitive difficulties.
- Babies are sensitive to changes in their environment, and to their rhythms and routines. They react to different temperatures, smells, noises, touch, and visual stimulation in different households.
- Abrupt moves can upset sense of security, and babies become less flexible in the future. Their sense of developing trust in a predictable world is disrupted.
- At 6 months, babies begin to differentiate caregivers from strangers and reciprocate behaviors. Separation at this time can lead to diminished trust of caregivers and difficulties interacting.
- To lessen distress, the new environment should be made consistent with the old one, and routines and schedules should be maintained. Contact with the caregiver who the infant is attached to should be maintained through visitation or other means (i.e., article of caregiver's clothing in the baby's crib.)

TODDLER YEARS (12 TO 36 MONTHS)

- Separation interferes with balance between dependency and autonomy. If the child cannot count on the caregiver to be there when needed, she may be clingy and dependent, insisting on keeping the caregiver in her presence or, alternatively, too autonomous, withholding affection and being stubborn or resistant.
- Regression of recently acquired skills, such as potty training and language, and eating and sleeping problems are common.
- Children with multiple moves during the first three years are vulnerable to severe problems in the development of social emotions, which can impact interpersonal relationships, conscience development, and self-esteem later on.
- Identity formation is at risk during toddlerhood; changes in first names may cause extreme disruption.
- Caregivers need to take advantage of opportunities to be with their children and increase trust and age-appropriate autonomy.

PRESCHOOL YEARS (3 TO 6 YEARS)

- Magical and egocentric thinking affect reaction to parent loss. Children think they caused the loss through their wishes, thoughts, or behaviors. Loss during this time reinforces magical thinking, and it may persist longer as a result. Children cling to their own explanation for the placement. Self-blame increases anxiety and lowers self-esteem.
- Any placement of more than a few weeks is experienced as permanent. Without visitation, the child may assume the parents are gone and are not coming back.
- Behaviors may provide clues to a child's misconceptions. Caregivers and helpers should listen for comments and behaviors that seem to make no sense, but might be indicative of magical thinking. Children at this age cannot be convinced that their thinking is flawed, but effects can be overcome as the child gets older, if adults know the child's earlier thoughts.

SCHOOL AGE (6 TO 11 YEARS)

- Children use their family as a base of strength for dealing with outside challenges. If energy must be diverted to coping with separation and loss, it may interfere with their ability to accomplish the primary developmental tasks, such as education in school, developing friendships, and internalizing values and conscience.
- Separation is likely to cause temporary regression to more concrete thinking and less mature behaviors, and regression in school performance.
- Magical thinking has decreased, and children can understand time better and adjust to shorter separations. Fear of the unknown means that adults need to be honest with children about what is happening and how decisions are made.
- Children need supportive help to deal with separation. Children learn that they can continue to have strong feelings, both positive and negative, about people that they have a strong emotional connection to, but rarely see.
- Attachments can be maintained without frequent contact. Adults need to remember that children are still influenced by connections to past caregivers, even if ties have been severed.
- The Child Welfare Professional can help children recognize that feelings of ambivalence are normal (i.e., “Part of me feels sad, and part of me feels mad.”)

ADOLESCENCE (11 TO 19 YEARS)

- Parental loss is highly associated with depression.
- Separation may exacerbate emotional instability and impulsivity that are prominent during this stage, especially if separation was unwanted.
- Separation is often instigated by the adolescent. In these cases, the adolescent feels in control of the situation, but may focus his energy on getting out of a negative situation, rather than learning to solve problems and remaining in the current family setting.
- If the adolescent feels like she has lost control over her life, she may either become self-destructive or act out in a variety of ways.
- If the adolescent’s needs cannot be met by the family, he may turn to peers to meet desire for approval.
- Adolescents who experience parental separations are less likely to feel a sense of belonging.
- Ambivalence about the relationship with the caregiver who the adolescent is separated from can complicate and extend the grieving process.
- Parents need to understand that their youth need contact with them, regardless of how rejecting or angry they appear.

Factors that Influence a Child's Reaction to Parent Separation or Loss⁵

STRENGTH OF CHILD'S RELATIONSHIP TO CAREGIVER

- "In general, the stronger the relationship, the more traumatic the loss. In the absence of love, there is no pain in loss." (Fahlberg, 1991.)
- Children who are attached to their caregivers need to be helped to both grieve the separation and, if possible, maintain ties to the caregiver, while at the same time developing attachments to the new caregivers.

ABRUPTNESS OF SEPARATION AND CHILD'S PREPARATION FOR THE MOVE

- Children who experience abrupt separations are more likely to experience greater trauma and a prolonged grieving process.
- Children should be given the opportunity to say goodbye to the people, places, and familiar structures that they are leaving. They should be helped to understand the reasons, including what is planned for continued contact.
- Family members should be prepared for the child's arrival.
- The child should enter placement with as much information as possible, so that he or she knows what to expect.

PAST EXPERIENCE WITH SEPARATION

- Children who have experienced multiple placements are less likely to show a reaction to separation, because they have learned to guard against the pain, usually by avoiding becoming emotionally close to others. The result is an inability to form close attachments to others, which, ironically, increases the risk of another move, reinforcing the child's perception of the instability and high risk associated with forming relationships with caregivers.
- The easier it is to get a child out of a family, the harder it is to return the child to the home or find another home where he can develop close trusting relationships with caregivers.

THE POST-SEPARATION ENVIRONMENT

- The quality of the caregiver's environment subsequent to early parental loss is critically important to emotional development. A supportive, helpful environment can prevent lasting psychological damage from trauma.

THE CHILD'S TEMPERAMENT

- Children react differently to stress. Some children withdraw (psychologically or physically,) and some may act out. Either response can help or hinder the grieving process. The child welfare worker typically cannot change the child's temperament and characteristic patterns of dealing with stress, but he or she can work with the child's temperament to help the child to reach resolution. The caseworker can help caregivers understand the grieving process and the ways in which the child may express their feelings.

⁵ This material is adapted from Fahlberg, V. (1991). *A child's journey through placement*. Indianapolis, IN: Perspectives Press.

- For the withdrawn child, it is particularly important that the new caregiver does not withdraw in turn from an unresponsive child. These children may need help in learning to label their feelings, perhaps by talking about feelings other children might have in a similar situation. They also may need permission to express their feelings and support, even if their emotion makes adults uncomfortable.
- When children act out, the worker can help the caregiver confront the behavior but accept the emotion. Caregivers can model positive strategies for dealing with anger, such as punching a pillow. The adult should avoid isolating a child to discipline him or her. Time outs within the same room send the message that, when the child acts out, the adult is not afraid of the child's anger and will be there until he regains control.

THE ENVIRONMENT FROM WHICH CHILD IS BEING MOVED

- No matter how negative or unsafe the child's home environment may seem to others, from the child's perspective, it is familiar, and therefore preferable to the unknown.
- A child may be attached to an abusive parent, whom she both loves and fears. When threatened with separation, she will cling to the abusive parent with whom she has an attachment rather than go willingly with a caseworker, whom she is not attached to and also fears.
- The most frightening thing for a child is to be simultaneously afraid of and separated from the person to whom he is attached.

THE CHARACTER OF ADULT'S INTERACTIONS WITH CHILD

- Emotional tone of the parting message that the child receives should be positive (i.e., "More than anything, I hope that things go well for you," rather than, "You would not believe how difficult this has been.")
- Whenever possible, the caregiver from whom the child is being separated should explain what is happening and the placement process to the child.
- The "welcoming message" that the child receives should be warm and cordial. The child should never be greeted with apprehension or mistrust.
- Children should be allowed to express their emotions.

Phases of Grief

Kubler-Ross (1975) identified five phases of grief that most people move through when faced with a loss: shock/denial, anger, bargaining, sadness/despair, and resolution. These stages have proven to be helpful in understanding the mourning process in both adults and children. Although discussed here in sequence, people do not always move through these stages sequentially. After an initial reaction of shock/denial, the stages of anger, bargaining, and sadness/despair may occur in any order, and even may recycle, before the person comes to resolution. Cultural factors may also inhibit or facilitate movement through the stages. For example, in majority culture in this country, boys are taught to conceal grief: “Big boys don’t cry.” Anger is seen as a more acceptable expression of feelings for boys, and this cultural emphasis may lead to boys doing more acting out and even becoming “stuck” in the anger stage. Girls, on the other hand, are encouraged to repress their anger, and may become withdrawn, stuck in sadness/despair.

SHOCK/DENIAL

General Description of Stage

- Most prominent when separation is abrupt.
- Initial reaction to overwhelming psychological insult is to shut down.
- Denial is a mechanism that helps us prevent, avoid, or reduce anxiety when we feel threatened.
- Allows grieving children to suppress intense emotions that make them feel vulnerable and conserve energy needed for future adjustments.
- Offers “time-out” or reprieve from mourning.

Behavioral Expressions in Separated Children

- The child may show little emotion, seem numb and mechanical.
- The child may be prone to appetite and sleep disturbances, including frequent nightmares, and have difficulty paying attention or remembering tasks.
- The child may deny the loss and may make statements such as, “I’m not staying here. Mommy will get me soon.”

Diagnostic Implications

- The behavioral expressions of shock and denial are the same as those seen in extreme neglect. The worker needs to differentiate whether symptoms are secondary to chronic neglect or the trauma of parental separation, especially when the move has been abrupt.
- Workers, foster caregivers, and parents may misinterpret the child’s compliant and unemotional behavior, believing the child “did fine...it was an easy move.” When a child is thought to have handled a move without distress, delayed behavioral signs are often not recognized as separation trauma and part of the grieving process.
- Children who have not developed strong attachments to their parents or caregivers may not display an emotional reaction to the move at all.
- The absence of an emotional response by children in placement, beyond the short time period of the “shock” phase, should be of considerable concern to the worker and foster caregiver, as it may indicate an underlying emotional disturbance.

BARGAINING

General Description of Stage

- Behavior during this stage is often an attempt to regain control and to prevent the finality of the loss.
- Bargaining reflects the magical, egocentric thinking which accommodates most losses, but is especially prominent during years 3-5 and in adolescence. In this phase, even older children regress to magical thinking.
- Frequently takes the form of promises: “If only...then I promise I will....”
- The child may believe that a certain way of behaving or thinking will serve to prevent the finality of the loss.

Behavioral Expressions in Separated Children

- The child may be eager to please and will make promises to be good.
- The child may try to undo what she feels she has done to precipitate the placement.
- The child may believe that behaving or thinking in a certain way will bring about reconciliation. These behaviors may become ritualized, which may be the child’s attempt to formalize her “good behavior” and assure its consistency.
- The child may try to negotiate agreements with the foster caregiver or the worker, and may offer to do certain things in exchange for a promise that he will be allowed to return home.
- The child may appear moralistic in his beliefs and behavior; these behaviors often are a defense against failure in upholding his end of the “bargain.”

Diagnostic Implications

- The child’s behaviors represent a desperate attempt to control the environment and to defend against feelings of emotional turmoil.
- In reality, there is little chance of the child’s behaviors producing the desired results or reunification.
- Understanding this stage can lead to needed support when the child realizes the ineffectiveness of the bargaining strategy and begins to experience the full emotional impact of the loss.

ANGER

General Description of Stage

- The loss can no longer be denied. The first emotional response is anger.
- Anger is commonly displaced onto others, such as foster parents, peers, or caseworkers.
- Guilt, blaming others, and recriminations are common.
- Minor stimuli can lead to angry outbursts.
- In trying to regain control over their lives, children may be more likely to escalate ordinary requests into issues of control.

Behavioral Expressions in Separated Children

The child may:

- Be oppositional and hypersensitive.
- Display tantrum behaviors and emotional, angry outbursts.
- Withdraw, sulk, or pout, and may refuse to participate in social activities.
- Be overly sensitive to perceived slights.
- Act as if the world owes them, yet nothing is good enough to please them.
- Exhibit aggressive, rough behavior with other children.
- Break toys or objects, lie, steal, and exhibit other antisocial behaviors.
- Refuse to comply with requests.
- Make comparisons between her own home and the foster home, and her own home is preferred.
- Display sleeping or eating disturbances, and may not talk.

Diagnostic Implications

- The child's oppositional behavior may be disruptive to the foster caregivers.
- Confrontations between the caregivers and the child may lead to a struggle for control.
- The child may be inappropriately diagnosed as "severely behaviorally handicapped" or "emotionally disturbed," or may be punished for misbehavior.
- Caretakers can be more supportive and helpful in redirecting the child's feelings if the behavior can be properly identified as part of the grieving process.

SADNESS/DESPAIR

General Description of Stage

- This stage is characterized by expressions of despair and futility, listlessness (with or without extraordinary episodes of fear and panic,) withdrawal, and a generalized lack of interest in people, surroundings, or activities. The individual often cannot be comforted.

Behavioral Expressions in Separated Children

- The child appears to have lost hope and experiences the full impact of the loss.
- Social and emotional withdrawal and failure to respond to other people are common.
- The child may be touchy, “out of sorts,” and may cry with little provocation.
- The child may be easily frustrated and overwhelmed by minor events and stresses.
- The child may be listless, without energy.
- Activities are mechanical, without direction, investment, or apparent interest.
- The child may be distractible, have a short attention span, and be unable to concentrate.
- Regressive behaviors are common, such as thumb sucking, toilet accidents, and baby talk.
- Generalized emotional distress may be exhibited in both emotional and physical symptoms, particularly in young children. These include whimpering, crying, rocking, head banging, refusal to eat, excessive sleeping, digestive disorders, and susceptibility to colds, flu, and other illnesses.
- Clinging and increased dependence may emerge.

Diagnostic Implications

- This is a critical period in the child’s relationship with the parent. Once the child has completed the grieving process, it will be extremely difficult to re-establish the parent/child relationship. There may be a lapse of time between the separation and the onset of depression.
- Foster caregivers may feel frustrated and helpless by their inability to comfort or help the child.
- The Child Welfare Professional who recognizes the child’s depression as part of the grieving process will be more able to provide support or increase visitations to prevent the child from emotionally detaching from the parent.
- When the child tries to share feelings, helping adults should focus and bear witness to the pain. Helping adults need to validate the child’s feelings, rather than minimize their suffering or try to “put a positive spin” on the situation. Never ask a child to deny, postpone, or conceal feelings of anger, sadness, guilt, or shame.

RESOLUTION

General Description of Stage

- Resolution for children in the foster care system is the acceptance of having two sets of parents. (Doesn't mean they have to like it.)
- Acceptance is emotional rather than intellectual.
- Once the separation and loss have been accepted, the child once again has energy for continued growth and change.

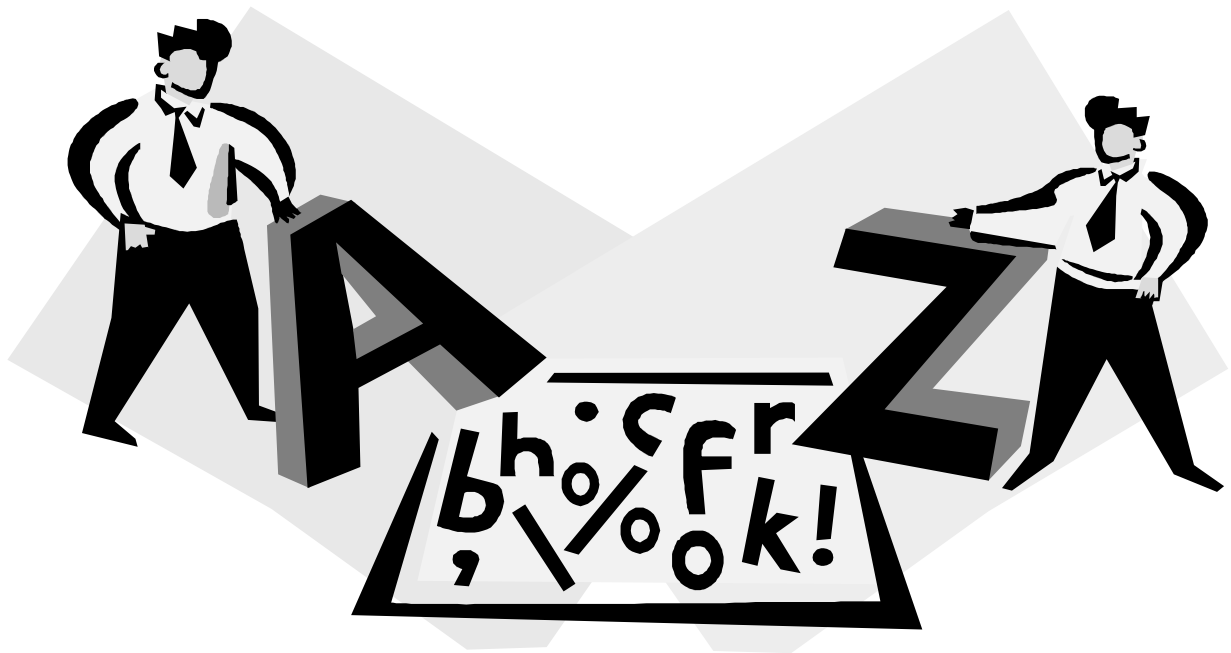
Behavioral Expressions in Separated Children

- The child begins to develop stronger attachments in the new home and tries to establish a place for herself in the family structure.
- The child may begin to identify herself as part of the new family and will demonstrate stronger emotional attachments to family members.
- The intensity of emotional distress decreases, and the child can once again experience pleasure in normal childhood.
- Goal-directed activities reoccur. The child's play and activities become more focused and playful. The child is better able to concentrate.
- Emotional reactions to stressful situations diminish as the child becomes more secure in the new environment.

Diagnostic Implications

- During the grieving process, tremendous energy is diverted from day-to-day relationships and the tasks associated with normal childhood development into coping with strong emotions.
- While resolution means acceptance, it does not mean that the child has to like what has happened, but rather that he/she accepts it in order to make progress and grow in other areas. The child who accepts that he has two or more families (rather than one replacing the other or families in sequence) may do better in coming to resolution.
- If the worker responds effectively with children at the point of crisis when they enter care and at subsequent crisis points, they may prevent many long-term developmental problems.

Glossary



Glossary

Adolescence: The period of life between puberty and adulthood, considered in this book to range from age 11 to age 19, though there are many individual variations. Adolescence is a period of transition from childhood to adulthood. In this book, this broad period is divided into two phases: early adolescence (11 to 15) and adolescence (15 to 19.)

Attachment: A close bond between two individuals based on strong feelings and involving continuing interaction that nurtures the relationship. Secure attachment allows for the completion of the developmental task Erikson describes for the first period of life: attaining “basic trust versus mistrust.”

Childhood: The period between birth and adolescence. For the phases of childhood, see *infancy*, *toddlerhood*, *early childhood*, and *middle childhood*, listed in alphabetical order in this glossary.

Domain: A specific sphere of growth and development containing a set of common characteristics. The domains considered in this book are *physical*, *cognitive* (including *language*), and *socioemotional*, (including *moral*.) These domains are closely interconnected developmentally; however, in any individual, growth in one may not exactly and consistently parallel growth in the others.

Early childhood: The period from approximately age 3 through age 5, as described in this book. Authorities vary somewhat in the time period they assign to each of the phases of childhood, and it is recognized that any such divisions are by nature somewhat arbitrary.

Echoing: The act of repeating what a child says for the purpose of helping his or her language development.

Embryo: The developing baby from 2 to 8 weeks after conception. Some authorities define the embryo period as 2 to 12 weeks.

Emotional intelligence: The ability to recognize, understand, and control one’s own emotions so as to use them in ways that promote not only personal well-being but also that of others and of society generally.

Expanding or recasting: Restating what an individual has said but in a more sophisticated form. This act helps children in language development.

Expressive vocabulary: The words an individual not only understands but can actually say. *See receptive vocabulary.*

Fetus: The unborn child from about 2 months after conception to the time of birth.

Fine motor skills: Those skills that enable the child voluntarily to reach for objects and to grasp, hold, and transfer them from hand to hand.

Gross motor skills: Those skills that enable the child to move around the environment efficiently, such as crawling, standing, and walking.

Identity formation: The process of deciding upon and beginning to form an identity as an individual with a specific place in society. According to Erikson, this is the defining task of adolescence.

Impediment: Anything that might keep a child from growing and developing as well as possible (abuse, neglect, lack of learning opportunities, crisis in the family, a physical or mental condition that could retard learning, and so on.)

Infancy: In this book, the period from birth to 12 months.

Labeling: Identifying aloud objects, animals, or individuals to help a child learn their names as part of speech development.

Marker: A milestone or attainment that measures the extent to which an individual has achieved typical, or normal, development in one of the four domains (e.g., in the physical domain, reaching a certain height and/or weight that is normal for the person's age.)

Menarche: The onset of menstruation in girls. Though this is sometimes named as a sign of beginning puberty, it actually occurs rather late in puberty. There is no comparably obvious marker in boys.

Middle childhood: The period of roughly ages 6 to 11.

Need: What an individual requires to grow and develop optimally (e.g., an infant needs frequent, loving touch to experience optimum growth emotionally and possibly even physically.)

Neuron: A nerve cell. Neurons form the basic raw material of the brain.

Normal: In accordance with the established norm or average. In child development, there is a "range" of normal that allows for individual variations, usually within 6 months on either side of the norm.

Prenatal: The developmental period before birth when a child is carried in the uterus.

Puberty: A series of changes, beginning, on average, around 10½ years in girls and 12½ in boys, involving the maturation of the reproductive organs and accompanying secondary sexual characteristics. In the female, menstruation first occurs in late puberty. By late puberty, individuals become capable of reproduction. There is a wide variation in when individuals begin and complete the processes of puberty.

Receptive vocabulary: The words an individual can discern and understand but cannot yet say. *See expressive vocabulary.*

Synapse: Connections among neurons in the brain. Synapses form the pathways that connect parts of the brain and are the basis for its organization and function.

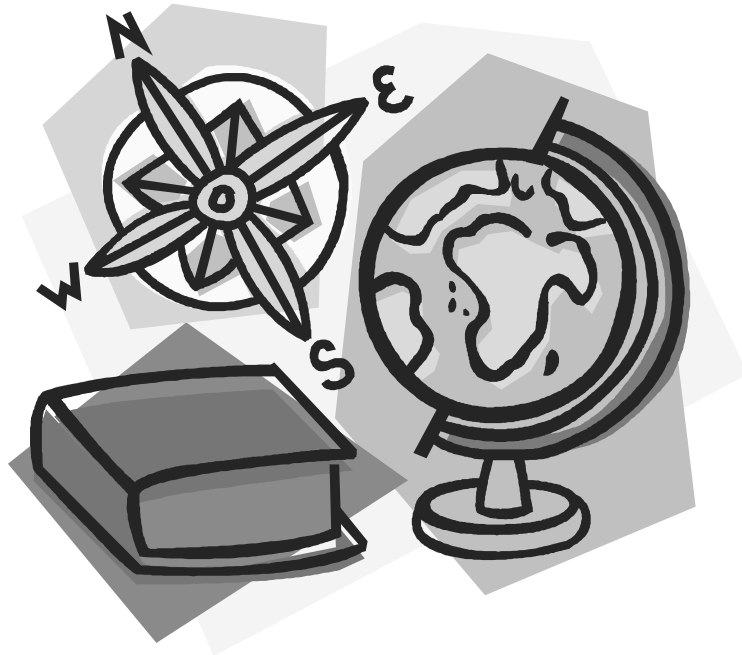
Task: A function that must be accomplished by the individual as part of growth and development (e.g., learning to walk.) Accomplishing a developmental task enables the individual to take on still more complex tasks.

Telegraphic speech: Two-word combinations that convey a meaning before a child is able to put whole sentences together (e.g., "more juice" or "baby cry.")

Teratogens: Agents or conditions that can cause birth defects if ingested by the pregnant mother (e.g., alcohol, caffeine, cocaine, some prescription drugs, environmental pollutants, Rubella, HIV/AIDS, and so on.) These are believed potentially to do the most harm during the fetus's first 12 weeks, but because their effects are complex and research is not conclusive, it is better for pregnant women to avoid them throughout pregnancy.

Toddlerhood: Roughly the period from a child's first learning to walk to age 3. In this book, toddlerhood ranges from 12 to 36 months.

Suggested Resources



Suggested Resources

The items listed below cover a range of subjects related to child and adolescent growth and development. Some of them were used in developing this book. Like any good resource list, and like the individuals it addresses, it too should grow and develop. If you know of good resources that are not included here and should be, please tell us so that we can add them to the list.

Abrams, R. (1990). *Will it hurt the baby?* Reading, MA: Addison-Wesley.

Adamson, L. B. (1996). *Communication development during infancy*. Boulder, CO: Westview.

American Academy of Child and Adolescent Psychiatry. (1997). Retrieved Nov. 7, 2002, from <http://www.aacap.org/publications/factsfam/>.

Aneshensel, C. S., Pearlin, L. I., Mullan, J. T., Zarit, S. H., & Whitlatch, C. J. (1996). *Profiles in caregiving*. San Diego: Academic Press.

Angold, A. (1988). Childhood and adolescent depression: Research in clinical populations. *British Journal of Psychiatry*, 153, 476-492.

Astington, J. W. (1993). *The child's discovery of the mind*. Cambridge, MA: Harvard University Press.

Autti-Ramo, I. (2000). Twelve-year follow-up of children exposed to alcohol in utero. *Developmental Medicine and Child Neurology*, 42, 406-411.

Baron, N. (1992). *Growing up with language*. Reading, MA: Addison-Wesley.

Bartsch, K., & Wellman, H. M. (1995). *Children talk about the mind*. New York: Oxford University Press.

Beal, C. R. (1994). *Boys and girls: The development of gender roles*. New York: McGraw-Hill.

Begley, S. (1999, September 27). Shaped by life in the womb. *Newsweek*, 50-54.

Berk, L. E. (1999). *Infants and children: Prenatal through middle childhood* (3rd ed.). Boston: Allyn & Bacon.

Blake, J. (1989). *Family size and achievement*. Berkeley: University of California Press.

Blatt, R. J. R. (1988). *Prenatal tests*. New York: Vintage Books.

Block, G., & Kelly, J. (1994). *The transition to parenthood*. New York: Delacorte Press.

Bloom, B. S. (Ed.). (1985). *Developing talent in young people*. New York: Ballentine Books.

Booth, A., & Dunn, J. (Eds.). (1994). *Stepfamilies: Who benefits? Who does not?* Hillsdale, NJ: Lawrence Erlbaum Associates.

Bowlby, J. (1969) *Attachment and Loss, Vol. 1*. New York: Basic Books.

Bredenkamp, S., & Rosegrant, T. (Eds.). (1992, 1996). *Reaching potentials*. Washington, DC: National Association for the Education of Young Children.

Brittain, C., & Hunt, D. E. (Eds.) (2003). *American Humane's Helping in child protective services: A competency-based casework handbook*. New York: Oxford University Press.

Brody, L. R., & Hall, J. A. (1993). Gender and emotion. In M. Lewis & J. M. Haviland (Eds.), *Handbook of emotions* (pp. 447-460). New York: Guilford.

Brodzinsky, D., Schechter, M., & Henig, R. (1992). *Being adopted*. New York: Doubleday.

Brooks-Gunn, J., & Chase-Lansdale, P. L. (1995). Adolescent parenthood. In M. H. Bornstein (Ed.), *Children and parenting* (Vol. 3). Hillsdale, NJ: Lawrence Erlbaum Associates.

Brownlee, S. (1999, August 9). Inside the teen brain. *Newsweek*, 45-54.

Bruer, John. (1999). *The myth of the first three years: A new understanding of how learning occurs throughout life*. New York: Free Press.

Chase-Lansdale, P. L., & Vinovskis, M. A. (1995). *Escape from poverty: What makes a difference for children?* New York: Cambridge University Press.

Children's Defense Fund. (1998). *The state of America's children: Yearbook 1998*. Washington, DC: Author.

Children's Disabilities and Special Needs. (2001). Retrieved Nov. 7, 2002, from <http://www.comeunity.com/disability/adhd/add-adhd.html>.

Chodorow, N. (1974). Family structure and feminine personality. In M. Risoldo & L. Lamphere (Eds.), *Women, culture and society*. Stanford, CA: Stanford University Press.

Chodorow, N. (1989). *Feminism and psychoanalytic theory*. New Haven, CT: Yale University Press.

Cicchetti, D. (1987). Developmental psychopathology in infancy: Illustration from the study of maltreated youngsters. *Journal of Consulting and Clinical Psychology and Psychiatry*, 26, 85-96.

Clarke-Stewart, A. (1993). *Daycare* (rev. ed.). Cambridge, MA: Harvard University Press.

Clements, D. H. (1995). Teaching creativity with computers. *Educational Psychology Review*, 7, 141-149.

Coles, R. (1991). *The moral intelligence of children*. New York: Houghton Mifflin.

Coles, R. (1991). *The spiritual life of children*. New York: Houghton Mifflin.

Collins, W. A., Harris, M. L., & Susman, A. (1996). Parenting during middle childhood. In M. H. Bornstein (Ed.), *Handbook of parenting: Vol. 1. Children and parenting* (pp. 65-90). Mahwah, NJ: Lawrence Erlbaum Associates.

Connors, L. J., & Epstein, J. L. (1996). Parent and school partnerships. In M. H. Bornstein (Ed.), *Handbook of parenting: Vol. 4. Applied and practical parenting* (pp. 437-458). Mahwah, NJ: Lawrence Erlbaum Associates.

Cooper, K. (1992). *Kid fitness*. New York: Random House.

Cowan, C. P., & Cowan, P. A. (1992). *When partners become parents: The big life change for couples*. New York: Basic Books.

Cratty, B. J. (1986). *Perceptual and motor development in infants and children* (3rd ed.). Englewood Cliffs, NJ: Prentice-Hall.

Cummings, E. M., & Davies, P. (1994). *Children and marital conflict*. New York: Guilford.

Damon, W. (1988). *The moral child*. New York: Free Press.

Damon, W. (1995). *Greater expectations: Overcoming the culture of indulgence in America's homes and schools*. New York: Free Press.

Damon, W., & Hart, D. (1988). *Selfunderstanding in childhood and adolescence*. New York: Cambridge University Press.

De Bellis, M. D., Keshavan, M. S., Shifflett, H., Iyengar, S., Beers, S. R., Hall, J., & Moritz, G. (2002). Brain structures in pediatric maltreatment-related posttraumatic stress disorder: A sociodemographically matched study. *Biological Psychiatry*, 52(11), 1066-1078.

Developmental Disabilities Resource Center. (n.d.). Retrieved November 4, 2002 from <http://www.ddrcco.com/dddef.htm>.

Dorris, M. (1989). *The broken cord*. New York: Harper & Row.

Dubow, E. F., & Miller, L. S. (1996). Television violence viewing and aggressive behavior. In T. M. MacBeth (Ed.), *Tuning in to young viewers* (pp. 117-147). Thousand Oaks, CA: Sage.

Dubowitz, H., & Black M. (1998). *The connection between failure to thrive and child neglect*. Presentation at the 12th National Conference on Child Abuse and Neglect, Cincinnati, OH, November, 1998.

Dubowitz, H., Harrington, D., Staff, R., Zuravin, S., & Sawyer, R. (1994). Children in kinship care: How do they fare? *Children and Youth Services Review*, 16(1/2), 85-106.

Dunn, J. (1989). *Young children's close relationships*. Newbury Park, CA: Sage.

Dunn, J., & Kendrick, C. (1982). *Siblings: Love, envy, and understanding*. Cambridge, MA: Harvard University Press.

East, P., & Felice, M. E. (1996). *Adolescent pregnancy and parenting*. Hillsdale, NJ: Lawrence Erlbaum.

Eckenrode, J., Laird, M., & Doris, J. (1993). School performance and disciplinary problems among abused and neglected children. *Developmental Psychology*, 29(1), 53-62.

Edelman, M. W. (1995). *The state of America's children*. Washington, DC: Children's Defense Fund.

Einstein, E., & Albert, L. (1986). *Strengthening your stepfamily*. Circle Pines, MN: American Guidance Service.

Eisenberg, A., Murkoff, H., & Hathaway, S. (1989). *What to expect when you're expecting* (2nd ed.). New York: Workman.

Elkind, D. (1991). *All grown up and no place to go: Teenagers in crisis*. Reading, MA: Addison-Wesley.

Ely, R. (1997). Language and literacy in the school years. In J. Berko Gleason (Ed.), *The development of language* (4th ed., pp. 398-439). Boston: Allyn & Bacon.

Erikson, E. H. (1950). *Childhood and society*. New York: Norton.

Erikson, E. H. (1968). *Youth and crisis*. New York: Norton.

Fahlberg, V. (1991) *A child's journey through placement*. Indianapolis, IN: Perspectives Press.

Famularo, R., Kinscherff, R., & Fenton, T. (1990). Symptom differences in acute and chronic presentation of childhood post-traumatic stress disorder. *Child Abuse and Neglect*, 14, 439-444.

Feingold, A (1992). Sex differences in variability in intellectual abilities: A new look at an old controversy. *Review of Educational Research*, 62, 61-84.

Feingold, A. (1993). Cognitive gender differences: A developmental perspective. *Sex Roles*, 29, 61-84.

Feldman, S. S., & Elliott, G. R. (Eds.). (1990). *At the threshold: The developing adolescent*. Cambridge, MA: Harvard University Press.

Ferber, R. (1985). *Solve your children's sleep problems*. New York: Simon & Schuster.

Field, T. (1990). *Infancy*. Cambridge, MA: Harvard University Press.

Feild, T. & Winterfeld, A. (2003). *Tough problems, tough choices: Guidelines for needs-based service planning in child welfare*. Englewood, CO: American Humane and Casey Outcomes and Decision-Making Project.

Flavell, J. H. (1985). *Cognitive development* (2nd ed.). Englewood Cliffs, NJ: Prentice-Hall.

Freud, S. (1917). *A general introduction to psychoanalysis*. New York: Washington Square Press.

Furstenberg, F. F., Jr., & Cherlin, A. J. (1991). *Divided families*. Cambridge, MA: Harvard University Press.

Galinsky, E., & David, J. (1988). *The preschool years*. New York: Times Books.

Gardner, H. (1980). *Artful scribbles: The significance of children's drawings*. New York: Basic Books.

Gardner, H. (1993). *Multiple intelligences: The theory in practice*. New York: Basic Books.

Gelman, R., & Au, T. K. (Eds.). (1996). *Perceptual and cognitive development* (2nd ed.). San Diego, CA: Academic Press.

Gilligan, C. (1993). *In a different voice: Psychological theory and women's development* (2nd ed.). Cambridge, MA: Harvard University Press.

Ginott, H. G. (1969). *Between parent and teenager*. New York: Avon.

Ginsberg, H. P., & Oppen, S. (1988). *Piaget's theory of intellectual development* (3rd ed.). Englewood Cliffs, NJ: Prentice-Hall.

Glaser, D. (2000). Child abuse and neglect and the brain: A review. *Journal of Child Psychology, Psychiatry, and Allied Disciplines*, 41(1), 97-116.

Goleman, D. (1995). *Emotional intelligence*. New York: Bantam.

Graber, J. A., Brooks-Gunn, J., & Petersen, A. C. (Eds.). (1996). *Transitions in adolescence*. Hillsdale, NJ: Lawrence Erlbaum Associates.

Gurian, M. (1996). *The wonder of boys: What parents, mentors, and educators can do to help shape young boys into exceptional men*. Los Angeles: Tarcher.

Halpern, D. F. (1997). Sex differences in intelligence. *American Psychologist*, 52, 1091-1102.

Hartup, W. W. (1996). The company they keep: Friendships and their developmental significance. *Child Development*, 67, 1-13.

Haskett, M. E., & Kistner, J. A. (1991). Social interactions and peer perceptions of young physically abused children. *Child Development*, 62, 979-990.

Hetherington, S. E. (1990). Coping with family transitions: Winners, losers, and survivors. *Child Development*, 60, 1-14.

Hochstadt, N. J., Jaudes, P. K., Zimo, D. A., & Schachter, J. (1987). The medical and psychosocial needs of children entering foster care. *Child Abuse and Neglect*, 11, 53-62.

Holden, G. W. (1996). *Parents and the dynamics of child rearing*. Boulder, CO: Westview.

Horney, K. (1967). *Feminine psychology*. New York: Norton.

Howard, M., & McCabe, J. B. (1992). Helping teenagers postpone sexual involvement. *Family Planning Perspectives*, 22, 21-26.

Huston, A. C., & Wright, J. C. (1998). Mass media and children's development. In I. E. Sigel & A. Renninger (Eds.), *Handbook of child psychology: Vol. 4. Child psychology in practice* (5th ed., 999-1058). New York: John Wiley.

Kaler, S. R., & Kopp, C. B. (1990). Compliance and comprehension in very young toddlers. *Child Development*, 61, 1997-2003.

Kalter, N. (1990). *Growing up with divorce*. New York: Free Press.

Kaufman, J., & Charney, D. (2001). Effects of early stress on brain structure and function: Implications for understanding the relationship between child maltreatment and depression. *Development and Psychopathology*, 13(3), 451-471.

Kendrick, A. S., Kaufman, R., & Messenger, K. P. (1991). *Healthy young children: A manual for programs*. Washington, DC: National Association for the Education of Young Children.

Kiser, L. J., Heston, J., Millsap, P. A., & Pruitt, D. B. (1991). Physical and sexual abuse in childhood: Relationship with Post-traumatic Stress Disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 30(5), 776-783.

Kohlberg, L. (1984). *Essays on moral development. Vol. 2: The psychology of moral development*. San Francisco: Harper & Row.

Koverola, C. & Foy, D. (1993). Post Traumatic Stress Disorder symptomatology in sexually abused children: Implications for legal proceedings. *Journal of Child Sexual Abuse*, 2(4), 119-128.

Krause, C. (1995). *How healthy is your family tree?* New York: Simon & Schuster.

Kurtz, P. D., Gaudin, J. M., Howing, P. T., & Wodarski, J. S. (1993). The consequences of physical abuse and neglect on the school age child: Mediating factors. *Children and Youth Services Review*, 15, 85-104.

Lerner, R. M., Petersen, A. C., & Brooks-Gunn, J. (Eds.). (1991). *Encyclopedia of adolescence*. New York: Garland.

Lipson, E. (1991). *The New York Times parent's guide to the best books for children*. New York: Random House.

Mahler, M. S., Pine, F., & Bergman, A. (1975). *The psychological birth of the human infant*. New York: Basic Books.

Marcus, D. L., Mulrine, A., & Wong, K. With D. Lackaff. (1999, September 13). How kids learn. *U.S. News & World Report*, 127(10), 44-52.

McLanahan, S., & Sandefur, G. (1994). *Growing up with a single parent*. Cambridge, MA: Harvard University Press.

Moore, K. L., & Persaud, T. V. N. (1993). *Before we are born: Essentials of embryology and birth defects* (4th ed.). Philadelphia: W. B. Saunders.

National Alliance for the Mentally Ill. (2001). Retrieved November 4, 2002, from <http://www.nami.org/helpline/depress.htm>.

Newman, B. M., & Newman, P. R. (1991). *Development through life*. Pacific Grove, CA: Brooks/Cole

Ornoy, A. (2002). The effects of alcohol and illicit drugs on the human embryo and fetus. *Israel Journal of Psychiatry and Related Sciences*, 39(2), 120-132.

Owens, R. (1996). *Language development: An introduction* (4th ed.). Boston: Allyn & Bacon.

Pfeffer, C. R. (1996). *Severe stress and mental disturbance in children*. Washington, DC: American Psychiatric Press.

Piaget, J. (1932). *The moral judgment of the child*. New York: Harcourt Brace Jovanovich.

Piaget, J. (1952). *The origins of intelligence in children*. New York: International Universities Press.

Piaget, J. (1954). *The construction of reality in the child*. New York: Basic Books.

Pruitt, D. B. (Ed.). (1999). *Your adolescent*. New York: American Academy of Child and Adolescent Psychiatry.

Reich, P. A. *Language development*. Englewood Cliffs, NJ: Prentice-Hall.

Roberts, W., & Strayer, J. (1996). Empathy, emotional expressiveness, and prosocial behavior. *Child Development*, 67, 449-470.

Salk, L. (1992). *Familyhood*. New York: Simon & Schuster.

Salzinger, S., Feldman, R. S., Hammer, M., & Rosario, M. (1993). The effects of physical abuse on children's social relationships. *Child Development*, 64, 169-187.

Samuels, M., & Samuels, N. (1996). *The new well pregnancy book*. New York: Fireside.

Sanson, A., & Rothbart, M. K. (1995). Child temperament and parenting. In M. H. Bornstein (Ed.), *Handbook of parenting* (Vol. 4). Hillsdale, NJ: Lawrence Erlbaum Associates.

Santrock, J. W. (1998). *Adolescence* (7th ed.). Burr Ridge, IL: McGraw-Hill.

- Santrock, J. W. (1998). *Child development* (8th ed.). New York: McGraw-Hill.
- Santrock, J. W. (1999). *Life span development* (7th ed.). New York: McGraw-Hill.
- Sarafino, E. P., & Armstrong, J. W. (1986). *Child and adolescent development* (2nd ed.). St. Paul, MN: West.
- Sawyer, R. J., & Dubowitz, H. (1994). School performance of children in kinship care. *Child Abuse and Neglect*, 18(7), 587-597.
- Schaffer, H. R. (1996). *Social development*. Cambridge, MA: Blackwell.
- Shonk, S. M., & Cicchetti, D. (2001). Maltreatment, competency deficits, and risk for academic and behavioral maladjustment. *Developmental Psychology*, 37(1), 3-17.
- Siegler, R. S. (1996). *Children's thinking* (3rd ed.). Upper Saddle River, NJ: Prentice-Hall.
- Silverman, W. K., La Greca, A. M., & Wasserstein, S. (1995). What do children worry about? Worries and their relation to anxiety. *Child Development*, 66, 671-686.
- Simons, J., Finlay, B., & Yang, A. (1993). *The adolescent and young adult fact book*. Washington, DC: Children's Defense Fund.
- Small, S. A. (1990). *Preventive programs that support families with adolescents*. Washington, DC: Carnegie Council on Adolescent Development.
- Smith, J. et al. (1997). *Understanding the medical diagnosis of child maltreatment: A guide for nonmedical professionals* (revised, 2nd ed.). Englewood, CO: American Humane Association.
- Sorenson, E. S. (1993). *Children's stress and coping*. New York: Guilford Press.
- Spock, B., & Parker, S. J. (1998). *Dr. Spock's baby and child care* (7th ed.). New York: Pocket Books.
- Spreadbury, C. L. (1982). First date. *Journal of Early Adolescence*, 2, 83-89.
- Steinberg, L., & Levine, A. (1990). *You and your adolescent*. New York: Harper Perennial.
- Stocker, C., & Dunn, J. (1991). Sibling relationships in adolescence. In R. M. Lerner, A. C. Petersen, & J. Brooks-Gunn (Eds.), *Encyclopedia of adolescence* (Vol. 2). New York: Garland.
- Strasburger, V. C. (1995). *Adolescents and the media*. Newbury Park, CA: Sage.
- Sullivan, P. M., & Knutson, J. F. (2000). Maltreatment and disabilities: A population-based epidemiological study. *Child Abuse and Neglect*, 24(10), 1257-1273.
- Takanishi, R. (1993). Changing view of adolescence in contemporary society. In R. Takanishi (Ed.), *Adolescence in the 1990s*. New York: Teachers College Press.
- Teyber, E. (1992). *Helping children cope with divorce*. New York: Lexington Books.
- Tharp, R. G., & Gallimore, R. (1994). *Rousing minds to life: Teaching, learning, and schooling in social context*. New York: Cambridge University Press.
- Throne, B. (1993). *Gender and play: Girls and boys in school*. New Brunswick, NJ: Rutgers University Press.
- Tucker, L. A. (1987). Television, teenagers, and health. *Journal of Youth and Adolescence*, 16, 415-425.
- Turecki, S., & Tonner, L. (1989). *The difficult child*. New York: Bantam Books.
- Updegraff, K. A., McHale, S. M., & Crouter, A. C. (1996). Gender roles in marriage: What do they mean for girls' and boys' school achievement? *Journal of Youth and Adolescence*, 25, 73-85.
- U.S. Department of Education. (1993). *Violence in the schools*. Washington, DC: Author.

U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, (2001). *Understanding the effects of maltreatment on early brain development*. Washington, D.C.: Author.

Walker, L. J. (1991). Sex differences in moral development. In W. M. Kurtines & J. Gewirtz (Eds.), *Moral behavior and development*, Vol. 2. Hillsdale, NJ: Lawrence Associates.

Ward, C. D. (1996). Adult intervention: Appropriate strategies for enriching the quality of children's play. *Young Children*, 51, 20-25.

Wass, H., & Stillion, J. M. (1988). Death in the lives of children and adolescents. In H. Wass, F. M. Berardo, & R. A. Neimeyer (Eds.), *Dying: Facing the facts* (2nd ed.). Washington, DC: Hemisphere.

West, L. L. (Ed.) (1991). *Effective strategies for dropout prevention of at-risk youth*. Gaithersburg, MD: Aspen.

White, B. (1990). *The first three years of life*. (rev. ed.). New York: Prentice-Hall.

Wicks-Nelson, R., & Israel, A. C. (1996). *Behavior disorders of childhood* (3rd ed.). Upper Saddle River, NJ: Prentice-Hall.

Winner, E. (1996). *Gifted children: Myths and realities*. New York: Basic Books.

WEBSITES

There are many websites related to child and adolescent development. Those listed below are general and, for the most part, noncommercial. They will lead you to other resources—some of them more specialized. If you do not find the information you need through these sources, you may want to conduct an Internet search on the specific topic(s) in which you have an interest.

- Attention Deficit Disorder Association (ADDA): www.add.org. Information on diagnosis, treatment, and education options for adults and young adults with ADD/ADHD.
- Child Development Institute: www.cdipage.com. Information on topics such as child development, learning and learning disabilities, parenting skills, health and safety issues, parenting of adolescents, communication, and parental stress.
- Department of Child and Family Development, University of Georgia College of Family and Consumer Sciences: www.fcs.uga.edu/outreach. Brain development and learning materials from the Better Brains for Babies project.
- Early Childhood Education Web Guide: www.ecwebguide.com. Information on child development, antibias resources, discipline and guidance, health and safety, learning, child advocacy, and more.
- KidSource: www.kidsource.com. Growth charts and other child development information.
- Mental Health Net: www.mentalhelp.net. Links to a variety of resources and organizations on child and adolescent mental health.
- National Center for Learning Disabilities: www.ld.org. Resources, information and fact sheets, tips for living with LD, and legislative and policy information.
- National Institute of Child Health and Human Development: www.nichd.nih.gov. Health and developmental information from current research, news releases on developmental topics, statistics on epidemiology, and prevention.
- National Network for Child Care: www.nncc.org. Material from a host of academic experts on a wide range of developmental topics, including ages and stages, developmental domains, brain development, developmental barriers, and family and other life stressors that may affect development.
- StorkNet: www.pregnancyguideonline.com. A week-by-week guide to what to expect in pregnancy.
- Zero to Three: www.zerotothree.org. Resources for parents and professionals specifically targeted to young children.

CREDITS

The Fetal Development Chart on pages 20-21 used the following sources of information:

- Moore, K. L., & Persaud, T. V. N. (1993). *Before we are born: Essentials of embryology and birth defects* (4th ed.). Philadelphia: W. B. Saunders.
- StorkNet: www.pregnancyguideonline.com. A week-by-week guide to what to expect in pregnancy.

The Growth Charts on pages 24-29 are from www.about.com and were originally published by the National Center for Health Statistics (www.cdc.gov/growthcharts/).